INVISIBLE WOUNDS: EXAMINING THE DISABILITY COMPENSATION BENEFITS PROCESS FOR VICTIMS OF MILITARY SEXUAL TRAUMA

HEARING

BEFORE THE

SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

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Wednesday, July 18, 2012

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS,
Washington, D.C.

The Subcommittee met, pursuant to call, at 2:09 p.m., in Room 334, Cannon House Office Building, Hon. John Runyan [Chairman of the Subcommittee] presiding.

Present: Representatives Runyan, Turner, McNerney, and Michaud.

Also Present: Representatives Pingree, Speier.

OPENING STATEMENT OF CHAIRMAN JON RUNYAN

Mr. RUNYAN. Good afternoon, and welcome to our hearing, Invisible Wounds: Examining the Disability Benefits Compensation Process for Victims of Military Sexual Trauma.

First I ask unanimous consent to welcome a number of honorable colleagues who have asked to be allowed here to participate as guest members of the Subcommittee today. Hearing no objection, so ordered.

As a Nation, we call on our armed servicemembers to sacrifice bravely on our behalf. They courageously put their lives at risk and face deadly enemies on the battlefield.

When we think of these enemies, we think of those who oppose our freedom and our American way of life. We certainly do not think of soldiers needing to defend themselves from their fellow servicemembers. However, many of our servicemembers are required to do just that.

Women are the fastest growing population among veterans, making up eight percent of the armed forces. However, the Department of Defense estimates that one in four women who join the armed services will be raped or assaulted, but that only about ten percent of such instances are ever reported.

Even more alarming is that of those few who did report the incidence of military sexual trauma, over 75 percent stated that they would not have made the same decision about reporting the incident again due to the consequences it had on their military career.

Despite the fact that many of these incidents go unreported, VA currently estimates that over half a million veterans have experienced military sexual trauma. This includes 17 percent of veterans from recent conflicts in Iraq and Afghanistan.

Although this is not the Committee's jurisdiction, there must be zero tolerance for this behavior in our military and the VA must recognize immediately the trauma inflicted on these men and women.

Accordingly, the focus of today's hearing is how to assist these veterans in obtaining VA benefits for post-traumatic stress disorder or PTSD. This is often a difficult task given the sensitive nature of these claims and the lack of evidence documenting such incidents at the time that they occurred.

Although VA has made great progress in adjudicating military sexual trauma claims by providing relaxed evidentiary standards and retraining employees on this issue, SWAN, one of the organizations testifying today, estimates that less than one-third of military sexual trauma PTSD claims are approved by the VA even though 53 percent of PTSD claims are granted overall.

Although military sexual trauma is not a new issue, it is a serious matter which more light needs to be shed on. In recent years, as more and more of our brave servicemembers find the inner strength to overcome military cultural challenges and come forward to seek justice, help and healing, the more the Members of this Committee, DoD, and VA can understand the best means of assisting victims of military sexual trauma by obtaining the VA benefits that they need.

One such veteran will be testifying before us today and I would like to personally thank Ms. Ruth Moore for coming to Washington and sharing her story with us today.

Victims of military sexual trauma like Ms. Moore can carry scars in their hearts for the rest of their lives as a result of what they have endured. Such veterans are indeed deserving of VA benefits to help them enjoy the American way of life that their service has helped to secure.

As the Department of Defense continues to address the issues arising from cultural resistence to reporting such abuse, the VA must continue to work to ensure that the proper benefits so needed by these victims are easily obtainable.

So I will reiterate that the focus of the hearing today is precisely that. What benefits does the VA provide for victims of military sexual trauma, how are these claims adjudicated, and how can this process be improved?

We welcome several witnesses to testify before us today ranging from representatives from veteran service organizations to experts on the effects and treatments of military sexual trauma to officials from the VA and the Department of Defense.

I appreciate all of you taking the time to speak with us today about this issue of such importance to so many members of our American community.

Because we have many distinguished guests with us today, I would like to reiterate my request that our witnesses abide by the decorum and rules of this hearing by summarizing your statements in five minutes or less during the oral testimony. Doing so will en-

sure that the Committee has the opportunity to hear from everyone.

I would also like to remind all present that without any objection, your written testimony will be made part of the hearing record. Hearing none, so ordered.

I now call on the distinguished Ranking Member from California, Mr. McNerney, for his opening statement.

[THE PREPARED STATEMENT OF CHAIRMAN JON RUNYAN APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. JERRY MCNERNEY, RANKING DEMOCRATIC MEMBER

Mr. MCNERNEY. Thank you.

Good afternoon. I would like to thank everyone for attending today's hearing which examines the VA's disability compensation process as it pertains to military sexual trauma or MST.

I am happy to join DAMA Subcommittee Chairman Runyan and my colleagues today in holding this hearing. I am also pleased that two leading voices of the Congress on this issue, Representative Shellie Pingree of Maine and Representative Jackie Speier of California, are accompanying the Subcommittee on the panel today.

I also welcome and thank Ms. Pingree's constituent, Ruth Moore, accompanied by her husband, for testifying about her MST experience with the VA.

Servicemembers who experience military sexual trauma, who are brave enough to speak out about their experiences often do so at great risk to their reputation and their careers.

The purpose of today's hearing is to evaluate ways in which the Veterans Benefits Administration and the Department of Defense can better address the needs of veterans affected by MST, to identify ways to prevent these horrible assaults and to treat and properly compensate the victims.

MST refers to sexual harassment, sexual assault that occur in military settings. MST often occurs in a setting where the victim lives and works which means that the victims must continue to live and work closely with their perpetrators.

Many MST victims state that when they do report an incident, their story is dismissed or they are encouraged to keep silent because of the need to preserve organizational cohesion.

This is unfair to the victims. We must put protections in place to ensure a safe haven exists for women and men who experience military sexual trauma. Unfortunately, the consequences of MST are a pervasive problem within the veteran community.

According to the Institute of Medicine, prevalence rates of MST range from 20 to 43 percent. Many veterans who are victims of MST express frustration with the VA's disability claims process, especially in trying to prove that the assault ever happened.

For many women and men, their disability claims for post-traumatic stress related to MST are denied. However, I am pleased that in July of 2010 in a response to action taken by this Committee, the VA relaxed its stressor evidentiary standards for post-traumatic stress which also includes MST.

While representing a step in the right direction, there are still hurdles that men and women face in receiving the benefits they deserve.

As SWAN will point out in its testimony, there are still disparities in compensation and confusion within the VBA on when service-connected compensation for MST is warranted.

Training at the VA has improved slightly, but VBA claims decisions are still inconsistent and more must be done.

As we build a VA for the 21st century, the VA and the DoD need to ensure that proper prevention, counseling, treatment, and benefits are available for MST victims.

Veterans should also have access to VA personnel who are qualified to advise on often sensitive MST related issues. These veterans need to be treated with the dignity and respect they deserve.

I look forward to hearing from the esteemed panel of witnesses. I thank you, and I yield back.

[THE PREPARED STATEMENT OF HON. JERRY MCNERNEY APPEARS IN THE APPENDIX]

Mr. RUNYAN. I thank the gentleman.

And at this time, I want to invite the first panel up to the witness table who are going to represent various veteran service organizations, and I welcome you to all come forward.

Our first guest is, and bear with me——

Ms. BHAGWATI. Anu Bhagwati, sir.

Mr. RUNYAN. Anu Bhagwati, thank you, who is the Executive Director of the Service Women's Action Network known as SWAN. Then we will welcome Ms. Joy Ilem, Deputy Legislative Director for Disabled American Veterans, and finally we will welcome Ms. Lori Perkio, the Assistant Director for Veterans Affairs and Rehabilitation for The American Legion.

We appreciate all of our witnesses for taking the time to testify before us today.

And, Ms. Bhagwati, you are now recognized for five minutes for your oral testimony.

STATEMENTS OF ANU BHAGWATI, EXECUTIVE DIRECTOR, SERVICE WOMEN'S ACTION NETWORK; JOY ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; LORI PERKIO, ASSISTANT DIRECTOR OF VETERANS AFFAIRS AND REHABILITATION, THE AMERICAN LEGION

STATEMENT OF ANU BHAGWATI

Ms. BHAGWATI. Thank you.

Dear Mr. Chairman and Members of the Committee, thank you for holding this hearing on a critical issue facing our veterans' community and for the opportunity to present the views of the Service Women's Action Network or SWAN on the challenges confronting veterans who file PTSD claims related to military sexual assault or sexual harassment.

According to VA, PTSD is the most common mental health condition associated with military sexual trauma or MST. For women veterans, MST is a greater predictor of PTSD than combat.

Studies also indicate that sexual harassment causes the same rates of PTSD in women as combat does in men and 40 to 53 percent of homeless women veterans have been sexually assaulted while in the military. Simply put, MST has devastated the veterans' community.

I would also like to point out that many men suffer from the effects of military sexual violence. According to the Department of Defense, 12 percent of all unrestricted sexual assault reports are made by men. Additionally, according to VA, almost 46 percent of the veterans who screened positive for MST in 2010 were men.

Veterans who suffer from the debilitating effects of MST face unique challenges in obtaining disability compensation from the VA.

In 2011, SWAN and the American Civil Liberties Union, ACLU, filed a Freedom of Information Act request with the VA for data on MST claims. The data obtained through litigation showed that between fiscal year 2008 and 2010, only 32.3 percent of MST-based PTSD claims were approved by VA compared to an approval rate of 54.2 percent for all other PTSD claims during this time.

Also, veterans who had their MST PTSD claims approved by VA or among those veterans who had those claims approved, women were more likely to receive a 10 to 30 percent disability rating whereas men were more likely to receive a 70 to 100 percent disability rating.

To reiterate, veterans who file a PTSD claim based on MST only have a one in three chance of getting their claim approved. Also, data suggests a strong gender bias in PTSD disability ratings in favor of men.

The MST claims process is broken at best. VA's PTSD policy discriminates in practice against veterans who are sexually assaulted or harassed while in uniform by holding them to an evidentiary standard which is not only higher than that of other groups of veterans suffering from PTSD but also completely unrealistic for the majority of survivors to meet.

The language in the regulation that establishes the required evidence for what VA calls an in-service personal assault differs radically from the language used to describe the evidence required for all other PTSD claims.

In fact, CFR 3.304, paragraph (f), the regulation, allows for lay testimony as acceptable evidence in all other PTSD cases except in cases of an in-service personal assault.

VA policy fails veterans for a variety of reasons. First, sexual assault and sexual harassment in the military are notoriously underreported. According to DoD, almost 87 percent of assaults go unreported meaning that official documentation of an assault rarely exists.

Secondly, prior to the new evidence retention laws passed in the 2011 NDAA, the services routinely destroyed all evidence and investigation records in sexual assault cases after two to five years leaving gaping holes in MST claims filed prior to 2012.

Lastly, the allowance of so-called secondary evidence described in the regulation does not take into consideration the reality that many victims do not report the incidents to anyone including fam-

ily members and for a variety of legitimate reasons including shame, stigma, embarrassment, or fear of retaliation.

Although sexual assault increases the chance of adverse emotional responses and behaviors, it does not mean that all MST claimants will experience those symptoms. In fact, SWAN has spoken to survivors who demonstrate changes in behavior not included in the regulation such as improved job performance as a means of coping with the trauma.

After a series of conversations, SWAN had with the Under Secretary of Benefits last year about VA's discriminatory practices, the under secretary issued a memo in June 2011 providing further guidance to claims officers and instituting training requirements for processing MST claims.

However, both the letter and the training simply reinforced the existing regulation which places a double standard on MST claimants.

To fix MST claims policy, VBA must immediately revise the regulation to provide language that establishes the same evidentiary requirements for MST-based PTSD claims that it does for other claims.

Furthermore, there should be no requirement that veterans filing MST claims go through an independent compensation and pension or C&P exam to verify that they have PTSD or any other conditions associated with MST. Veterans should not be forced to dig up their trauma for complete strangers who often lack the sensitivity or professional qualifications to speak to survivors of sexual trauma and who often unfairly reverse the PTSD diagnosis made by qualified VHA or other mental health providers.

Additionally, claims reviewers should not have the authority to second guess evaluations by agency medical professionals or to discount VA treatment records in favor of these one-time C&P exam results.

Thank you very much for your attention. I would be happy to answer any questions.

[THE PREPARED STATEMENT OF ANU BHAGWATI APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you, Ms. Bhagwati.

Next we will hear from Ms. Ilem.

STATEMENT OF JOY ILEM

Ms. ILEM. Thank you, Mr. Chairman and Members of the Subcommittee. We appreciate DAV being invited to testify on the disability claims process for post-traumatic stress disorder based on military sexual trauma or MST.

In preparing for this hearing, members of our National Service Officer Corps contacted a number of local VBA officials to determine what sources are being used by rating specialists in developing MST claims.

A December 2011 VBA national training letter was identified as an important guide. It provides detailed and comprehensive guidance regarding these claims including pertinent regulations, definitions, court cases, specific markers to examine, timing for ordering

PTSD examinations, and proper development actions to be taken all before a decision is made.

Most notably we found a number of clear examples and statements to raters emphasizing that a special obligation exists on VA's part to assist claimants in gathering from sources other than military service records evidence corroborating a stressor and to help fully develop their claims, particularly in MST cases.

The current regulation recognizes the difficulties inherent in establishing service-connection for conditions related to MST and provides a basis for a relaxed evidentiary standard.

The most salient point made in the training letter is to emphasize that current regulations and court cases do not require actual documentation of a claimed stressor and that the opinion of a qualified mental health clinician can be considered credible supporting evidence that the claimed stressor occurred.

Nevertheless, the letter notes that the final decision on service-connection remains with VBA raters.

To DAV, the question at hand for this Subcommittee is whether VBA rating specialists are applying the unique provisions in the regulation and following the specific guidelines.

In cases where veterans indicate that no official report of an assault exists, VA adjudicators must consider the stressor statement provided by the veteran to determine if other reports may document the event.

Additionally, rating specialists should examine military personnel records for any sign of deterioration in work performance, requests for transfer to another duty station, disciplinary action, or unexplained social or behavioral changes in the claimant.

Likewise, there are a number of medical complaints that may indicate a sexual assault took place such as a request for a pregnancy test or sexually transmitted diseases, repetitive trips to sick call with chronic, unresolved medical complaints can also be used collectively to help substantiate a stressor.

It appears that these cases require special attention and efforts by raters, but it remains unclear whether these efforts are consistently and exhaustively being made in each case.

Based on feedback from DAV national service officers, it appears that many of these claims are denied even when there appears to be sufficient documentation to support the claim under the liberal guidelines and lowered evidentiary standards.

We also continue to hear reports from veterans who have had to pursue their cases for years and ultimately seek congressional intervention before their claims were approved.

Additionally, a recent press report citing a Yale University legal services director documented a significantly lower percentage between VA's approval rates of claims for service-connection for MST related PTSD claims compared to service-connection of other PTSD claims as noted by Ms. Bhagwati.

However, we have not seen this type of data provided or substantiated by VBA.

In preparing for this hearing, we did, however, learn that VBA has an electronic capability to segregate and account for MST and personal assault cases from other types of PTSD claims. We believe open reporting of the status should be helpful to the Subcommittee

in its oversight role and could help to determine if there is truly an inequity in establishing service-connection in these cases.

Although VA has developed regulations and procedures that provide for a liberal approach to evidentiary development and adjudication of these claims, we urge VBA to conduct its own internal oversight and review of these cases to ensure that across the system its claims staff are properly trained and compliant with the procedures and policies set forth in the 2011 training letter.

In closing, we appreciate the Subcommittee's attention to this important issue and in the past decade, we note that progress has been made, but much more needs to be done to ensure that these disabled veterans are properly compensated for conditions related to MST on an equitable basis in comparison to veterans disabled by other causes.

Many of these veterans endured long, unnecessary waits for their claims to be approved and many report they have been re-traumatized by the process and bureaucracy that seems to surround these cases and ask only for a fair measure of justice given the indignities they have endured.

That concludes my remarks and I am happy to answer any questions you may have.

[THE PREPARED STATEMENT OF JOY ILEM APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you, Ms. Ilem.

Ms. Perkio, you are now recognized for five minutes.

STATEMENT OF LORI PERKIO

Ms. PERKIO. Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to provide The American Legion's views on the invisible wounds, examining the disability and compensation benefits process for victims of military sexual trauma.

Today's media provides a snapshot of the number of sexual assaults that are currently reported in the military. DoD estimates only 14 percent of all military sexual assaults are reported each year. It is estimated that a victim of military sexual trauma will wait an average of 12 years to report an incident.

VA health care screens all veterans for military sexual trauma and provides free treatment and health care for those related conditions. It is often through this screening and treatment that veterans learn about filing a claim for VA disability benefits secondary to military sexual trauma.

Filing a claim for PTSD due to military sexual trauma often causes extreme stress on behalf of the claimant as they have to repeat the events of the assault in support of their claim. It is highly recommended the veteran obtain an advocate familiar in the VA claims process to help them understand the requirements.

VA reported 704 MST claims were granted from October 2011 through February 2012. Seven hundred and twenty-six MST claims were denied in that same timeframe. I would like to provide you with some of the reasons that VA regional offices have denied claims for military sexual trauma.

The Veterans Benefits Administration requires three elements to grant a claim for disability benefits. The first is a current diagnosis of a disability from a medical professional.

The second is credible evidence that the claimed stressor occurred while the veteran served on active duty and proper record-keeping by the military unit may be critical to this requirement.

The third element is a nexus statement from a medical professional that the claimed condition is at least as likely if not due to the event which occurred while the veteran served. The requirements of the nexus statement are not clearly defined to the veteran.

In order for a medical statement to be accepted as credible, the medical professional must also have reviewed service treatment records, all private and VHA behavioral health treatment records, and reviewed all pertinent information submitted in support of the claim. The nexus statement must list all the records reviewed.

Rating veteran service representatives will not consider a medical statement as credible evidence if it is based solely on the verbal account of the veteran. VA may consider other evidence if there is no documentation within the military record such as a police report or medical examination specific to sexual assault.

If documentation of behavioral changes are not mentioned within the service treatment records and were provided by a behavioral health department instead, these records need to be requested separately and by the veteran.

The VA will obtain these records only if given the dates of treatment and the exact address of that treating facility. Most veterans do not realize this is not automatically included in their service treatment records.

VA states it will consider documentation of pregnancy tests or tests for sexually transmitted diseases around the time of the incident or treatment for physical injuries around the time of the incident that were not claimed as due to trauma.

While this information may be listed in the service treatment records, it may not state why the servicemember sought that type of treatment, especially if it is a result of sexual trauma they are not yet ready to discuss.

If the service medical records have any type of notation that treatment was requested due to other than sexual assault, it may be considered as conflicting evidence and often used as a reason to deny the claim.

Sudden requests for change in military occupation skill or requests for assignment changes without justification and changes in performance evaluation may be considered as credible evidence, especially if the documentation is within the military personnel file.

Not all RVSRs request a personnel file when requesting medical records. Without the personnel file to corroborate the alternate evidence listed in 38 CFR 3.304, this evidence is often based solely on the word of the veteran, which at this time VA does not consider as credible evidence.

The VA has the ability to use their own authority to reduce the number of denied claims for PTSD due to MST. In 2010, VA implemented the reduced criteria for post-traumatic stress disorder due to combat.

Obtaining personnel records must be a mandatory requirement with all PTSD claims in the VA's duty to assist. In addition, provide clear explanation and clarification of credible evidence to support the claim as outlined in 38 CFR 3.304.

I would like to thank you on behalf of The American Legion for providing testimony today.

[THE PREPARED STATEMENT OF LORI PERKIO APPEARS IN THE APPENDIX]

Mr. RUNYAN. I would like to thank you for your testimony.

And with that, I will begin the questioning of the first panel starting in order of our Members' arrival.

My first question is going to be to Ms. Ilem. You mentioned in your written testimony about collaborative efforts between the DoD and the VA in dealing with MST claims.

Do you believe that collaboration is adequate and how do you think this process can be improved?

Ms. ILEM. I think we have seen more collaboration with Secretary Hickey coming in, in terms of we looked at our last testimony that was before this Committee and specifically we had requested that VBA collaborate with SAPRO, the DoD's SAPRO office to make sure that the SAPRO information was included in their M21 manual.

And we were pleased that following that hearing, it did take about a year, but eventually it did make its way into the M21 manual as an opportunity for raters to look at, you know, one other location for either one of the DoD forms, 2910 or 11. So I think we have seen an increase in the cooperation.

However, we still have questions outstanding in our mind in terms of if VA requests that information, even with the permission of the veteran, due to the highly sensitive nature and DoD's wanting to protect the privacy of the veteran, if those will—will those records be forwarded because we had not seen that in SAPRO's documentation that VA is an exception of one of the people that can receive that documentation.

So I look forward to the panels following this, to hearing from them if that has been clarified and that they, in fact, are collaborating together to make sure that evidence is available for veterans who want it to be made available to VA in support of their claims.

Mr. RUNYAN. Thank you.

I think this Committee recognizes that many veterans are having difficulty receiving benefits related to MST. And despite the relaxed evidentiary standard, many veterans still have difficulty providing the evidence required for the award of service-connection.

In each of your opinions, can you touch upon, why that is happening?

Ms. BHAGWATI. I would not refer to them as relaxed evidentiary standards. I would refer to them as actually harder evidentiary standards.

There is a two-tier system right now, one for PTSD generally and then one for MST PTSD, and for veterans who suffer from MST, 87 percent of these assaults were never reported for very good reasons including fear of retaliation within the military and a variety

of other factors related to rape, assault, and the trauma that results.

We have to think more strategically about what counts as a fair evidentiary standard. It is clear in all other cases of PTSD that the veteran's lay testimony is sufficient as long as that veteran has a diagnosis of Post-Traumatic Stress Disorder from a qualified medical provider as well as proof of time and service.

There is language in that regulation for every other veteran suffering from PTSD with the exception of rape, assault, and harassment. It is completely unfair.

Mr. RUNYAN. Thank you.

Ms. Ilem.

Ms. ILEM. I think probably we would like to see the data. For years, we have asked for data specific to MST related cases versus non-personal assaults. The first information that we had really seen was the FOIA information. And certainly we believe VA does have the capability to extract that information and perhaps has it, just briefly looking at their testimony, VA appears to have evaluated some of the raters' decisions.

And I think we would definitely want to look at if these was there compliance with the rules and regulations and the policies that have been set forth so far. That is where I think probably the biggest, problem may lie because, there are oftentimes, a significant number of other opportunities to support those claims, but it appears perhaps they are not being consistent throughout the country because we continue to hear these complaints repeatedly from people that are saying I have, submitted a number of, everything that they have asked me and my claim was still denied.

Mr. RUNYAN. Ms. Perkio?

Ms. PERKIO. Thank you.

I have been a service officer for 16 years and I have been working VA claims. And that included military sexually trauma claims. And my experience as a service officer is that the evidence was not given the weight that it should have.

I worked with one man. He had been raped and the next morning as he was walking around feeling very dejected and trying to figure out what he was going to do with the rest of his life, he chose to commit suicide by throwing himself under a truck.

Not only did he have to live with the results of the medical injuries from that, the treatment that he received did not get used in support of his claim because he did not report that he had actually been sexually assaulted. The medical records and nobody in the VA would take into account the reasons why he may have tried to commit suicide when it was plain that there was definitely a change in his attitude, his personality, and his will to live.

Those are the types of things that we would like to see the VA take more into account in supporting claims for military sexual trauma.

In their own adjudication manual, it states behavioral changes will be considered. These are things that while the regulation is already there, the adjudication manual is there, more information needs to be provided to the raters on how to look at that information and apply it.

Mr. RUNYAN. Thank you.

And with that, I recognize the Ranking Member, Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Ms. Bhagwati, I believe that you mentioned that one of the problems that claimants have is that records have been purged after a certain number of years.

Do you know if that is a policy or what regulates when records are purged and how can we change that so that there is more evidence that would be maintained?

Ms. BHAGWATI. There are some records that are still purged and some that are no longer purged thanks to the last National Defense Authorization Act. Perhaps Congresswoman Pingree can add to that.

Unrestricted sexual assault reports are kept for 50 years and restricted reports for five years. What is still destroyed, however, is EO or sexual harassment investigations.

So if you were sexually harassed and reported it, and this happened to me, I can tell you my firsthand experience, those EO reports are destroyed within two to five years. And it is done branch to branch. I served in the Marines, so the Department of the Navy is not tracking those or not keeping those copies forever.

Mr. MCNERNEY. So there is no policy with regard to keeping those?

Ms. BHAGWATI. Not for sexual harassment investigations.

Mr. MCNERNEY. Well, you concluded in your testimony that when you look at the VA's policies on paper, it is no surprise that veterans who suffer from MST related PTSD have only a one in three chance of having their claims approved.

Could you please elaborate on that conclusion and how the VA regulations could be change to improve the outcomes of that?

Ms. BHAGWATI. It is an absolutely murderous process. We heard the example of one veteran who killed himself because of this process. But, you know, I went through it myself. It took four years.

Frankly, VBA is inept at the regional office level. You can give them all the evidence you have. I had plenty of eyewitness statements, everything they asked for, all the sort of secondary evidence that is in the regulation, but it was flat out ignored.

What happens when those claims get rejected is a lot of veterans fall into a downward spiral of worsening trauma, suicidal ideation, maybe attempted suicide, maybe completed suicide.

We are really looking at a life and death situation here with this claims process. And we do not need——

Mr. MCNERNEY. So it is not——

Ms. BHAGWATI. It is not rocket science. We do not need to rewrite, you know. It is not an issue of allowing more evidence. It is requiring less evidence. It is a very simple fix. We should have one universal standard for PTSD claims.

Right now lay testimony is not enough for sexual trauma survivors, but it should be in addition to the other requirements for all PTSD claims, a doctor's diagnosis or a mental health provider's diagnosis.

Mr. MCNERNEY. In your opinion, does it more have to do with the regulations or with the culture?

Ms. BHAGWATI. It is both. Unless there is a formal change in policy written in the regulation, you are counting on the individual re-

gional officer, the claims person or claims provider to make a judgment about whether or not a VHA diagnosis or a mental health provider's diagnosis of PTSD is accurate or enough based on their years of experience doing rape crisis counseling work or sexual trauma counseling work.

Essentially what happens is VBA gets to deny the expertise of its VHA experts or mental health professional experts. It is a completely backward system.

And, unfortunately, you are right. There is bias within each individual claims officer who rejects these claims. And we cannot risk that bias. A fix to this regulation is very simple.

Mr. MCNERNEY. Okay. Well, that is a good segue into Ms. Pingree's bill, H.R. 930. Do you think the provisions in this bill would help the veterans affected by MST in facing the hurdles that they have, Ms. Bhagwati?

Ms. BHAGWATI. Yes, absolutely. I think H.R. 930 is a comprehensive solution that includes, not just post-traumatic stress but all the other mental health conditions associated with sexual trauma.

Not everyone has PTSD from sexual assault, rape, or harassment. Other common conditions are other anxiety disorders, depression, and those are also life threatening.

Mr. MCNERNEY. Ms. Ilem, what in your opinion should be done to help the veterans that were denied claims prior to the recent improvements?

Ms. ILEM. I think certainly having VBA, you know, do a review of cases is extremely important since it sounds like they have invested in doing some training with their people. If they are really committed to making sure that people are consistently following these rules, they have to do the oversight internally.

I mean, it does take some work to develop these claims properly. And unless they go back and look, have those procedures been followed, and in those cases, I mean, they should, you know, think about reevaluating those claims. This has been a difficult process for so many people.

Mr. MCNERNEY. Do you think the VA should proactively do a system-wide review of the cases that have been denied?

Ms. ILEM. Well, I think they should definitely look back from their previous training letter that was done, I believe in 2005 prior to the update of the 2011 one, and would be a first good measure of looking at how well these standards have been applied in the regulation throughout those cases.

They did indicate, I believe in their statement, that following a review, I think that they did, that they decided to, you know, make changes in their letter and make it very clear and concise about how they wanted their raters to approach these cases. But we are not seeing the evidence in terms of were there cases denied that should have been approved based on the evidence.

Mr. MCNERNEY. Thank you.

Mr. Chairman, my time has expired.

Mr. RUNYAN. I thank the gentleman.

I now recognize the gentleman from Maine, Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman and Mr. Ranking Member, for having this very important hearing today and

also for the Committee for allowing my colleague from Maine, Ms. Pingree, to serve here as well.

And you do have the entire Maine delegation from the House here today, so it shows you the importance of this issue to have all of us here.

But I also want to thank Ruth Moore and her family for coming today as well and taking the time to talk about your personal story which is extremely important.

Unfortunately, Mr. Chairman, I will not be able to stay for the whole hearing as I have to meet with several employees from New Balance in Maine. They are currently negotiating the transpacific partnership agreement and depending on how that is negotiated would mean whether or not they will have to close the facilities or not. So I will not be able to stay for the whole hearing.

But I do have a quick question for our panelists. When you talk about, you know, some of the soldiers and veterans not reporting when they have been sexually assaulted, have you heard anything from the experience with the MST survivors as how soldiers actually should start documenting their issues when they are in the military? Have they given you any advice of what they should do for that documentation for any of the panelists?

Ms. PERKIO. I know that DoD has implemented a new program where victims of military sexual trauma can go in and receive counseling and they get to choose whether their records will be held or destroyed.

So if that servicemember says I just want treatment for this, I want you to help me through this program, but I do not want anything to follow me after this, and those records will stay destroyed.

And so DoD actually is working on a new program. I could not tell you the particulars or who that person is, but I could get you the point of contact after the hearing.

Mr. MICHAUD. That is what DoD is doing. But for those who have been sexually assaulted that you have talked to, have they given any additional suggestions on what DoD should do because clearly if they go in there, they are in the service, at that point in time, they might want to have everything destroyed, but when they start receiving help or what have you, they might decide to change their mind? So I am just looking for things that DoD can do differently that you might have heard from those who have been assaulted.

Ms. PERKIO. I have not been given any input from servicemembers, but I can tell you that working those claims, if all of the documentation was submitted and there was not a timeline to destroy behavioral health records and that they were, you know, integrated in with the service treatment records as well as their personnel records and file clerks were able to make sure that those records were complete, it would make a big difference on whatever action that servicemember chose to take at any point in their career either medically discharged or after they have been out filing a claim.

Ms. ILEM. I would just add that, you know, that was one of the problems with regard to SAPRO that we had that we spoke about at the last hearing here in 2010, our concern over the destruction, not only the destruction of records, but the recordkeeping process.

And as Ms. Bhagwati indicated, you know, that is still being sorted out. For the unrestricted, those records will be maintained for 50 years, but for the restricted ones, that is still in the works and they may be only maintained for up to five years.

And as well as any of these other additional records, it has been up to each military service, as we understood, determining when those would be destroyed or how long they would be kept. And we are concerned about where are they being kept and can VA get them if the veteran requests or indicates that they did have counseling or, you know, outside help.

So I think that is still a major issue on the DoD side and, again, look forward to the, you know, testimony by SAPRO if that has been worked out. We understand that, you know, Secretary Hickey and General Hertog have been talking about that, but to what extent, I do not know. We have not seen any formal agreements yet between the agencies.

Mr. MICHAUD. Thank you.

Ms. BHAGWATI. Survivors will universally talk about the bias in the system within DoD and the bias specifically within the chain of command. One of the reasons we have such a high under-reporting rate is because of that bias, because of that fear of retaliation. It is not just fear of retaliation, but actual retaliation which very often happens.

Here again, we are just talking about approximately the 13 percent that actually report and whose evidence can then, if it is not destroyed, actually be used for a VA claim. But VA's responsibility now has to be to the entire percentage of survivors including the 87 percent who do not report for very good reasons, for fear of their lives many times.

So in order to do that, there has got to be a change to the military judicial system so that there is no bias in that chain of command. And that is a longer conversation.

Mr. MICHAUD. Great.

Thank you very much, Mr. Chairman.

Mr. RUNYAN. I thank the gentleman.

And the gentleman from Minnesota, Mr. Walz, is now recognized.

Mr. WALZ. Thank you, Mr. Chairman, the Ranking Member, and thank you for once again holding important hearings on substantive matters and trying to make things right. I am very appreciative of that to both of you.

And to our witnesses, thank you for helping educate us, helping bring it forward.

As you do, I have such deep emotions on this as a retired military person. The anger and the disgust and the frustration all boil up on how do we end up in this point. It is just hard for me to fathom units that allow this to happen. And I recognize that it does.

On the VA side, I think Ms. Bhagwati brought up a very good point here. That 100 percent of folks here have to be dealing with it. But we have to go back to the DoD side. We have got to figure out the prevention measures, too.

And I know Ms. Pingree and Ms. Speier have worked heavily on this, that we have to continue to push that side of it.

As we are dealing with this tragedy after the fact. I think many of you brought up really good points of how this situation arose.

If you all three had the magic wand or were sitting over there at VA's position on this, what exactly would this look like? How we would deal with this? What exactly would happen from when the claim comes in and how we go forward? What would be your suggestion if you can help me as we are going to hear from them?

And I certainly know that we are trying to train specific raters to deal with this so they know what is there. I am just trying to get a feel from all of you. Are they going about this the right way? Are we approaching it? Are we piecemealing together? What would you tell me?

I know it is subjective here, but I think this is too important for us not to figure out something big to go about it. So if you would like to take a stab at that of what a claim should look like and how we should adjudicate these things that would be in the best interest of our servicemembers after the fact.

So, please, go ahead.

Ms. BHAGWATI. I am beating a dead horse here. I think this is, the third time I have said it.

Mr. WALZ. Yes.

Ms. BHAGWATI. It is a very easy fix. If the evidence establishes a diagnosis of post-traumatic stress during service and the veteran's mental health provider connects that claimed stressor to the patient's service, then in the absence of clear and convincing evidence to the contrary and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay testimony should sufficiently establish the occurrence of the claimed in-service stressor.

Mr. WALZ. Ms. Bhagwati, are you convinced that that will bring those 87 percent forward?

Ms. BHAGWATI. Absolutely. You trust your mental health providers and you accept the lay testimony and the military record of the veteran period.

Mr. WALZ. What is the push-back of why we do not do that in your opinion?

Ms. BHAGWATI. It is rape mythology, sir. It is the sort of unspoken feeling that women make up that they were raped, assaulted, or harassed. And I say women specifically because I think there is a gender bias.

Mr. WALZ. That does go back to the bigger cultural issue both military and social——

Ms. BHAGWATI. Absolutely. It is a complete ignorance about the nature of rape, sexual assault, and sexual harassment.

Mr. WALZ. Don't you believe, and I have always believed this, the military has the potential to break those and set the precedence for a larger society, too?

Ms. BHAGWATI. Absolutely. The military can lead the way if it wants to.

Mr. WALZ. Okay. Well, I appreciate that.

Ms. Ilem, I do not know if you have anything to add to that.

Ms. ILEM. I think Ms. Bhagwati has brought up a couple of issues that there is really a differentiation between somebody who may have some alternative evidence that can be considered and the current regulations that exist today to rate these cases because there is that aspect of it and making sure there is consistency

throughout the system across the board and then that there is oversight for them to really be reviewing it, and, yes, having claims raters that are familiar with these cases and really know how to dig in.

It seems to me they really have to make a special effort to kind of piece together other things and really work with the veteran and the RO military sexual coordinator may have to be involved to try and assist the veteran along with the veteran service organizations to get the evidence that is needed under the current regulation.

But the cases where somebody really keeps this a secret, does not tell anyone, there are not any indicators in the record to substantiate that.

We have seen legislation in the Senate recently that DAV testified on where, you know, if you are being treated for a condition, you have been diagnosed, and you then, you know, have, even though that stressor is not reported that can support, you know, support your claim, I mean, I think that is the only change that could be, you know, available to people who have—there is absolutely no other evidence available to them.

Mr. WALZ. And I think all of you brought up a great point on this, too. I cannot imagine what a claim denial feels like because it is basically a denial that the incident happened.

And, you know, I do not know if there is data that support the number of claims versus the number of denied claims. There definitely has to be a large number that were denied that the assault absolutely did happen. This is all a difficult process, from the psychological effects and treatment, to trying to get somebody well again, and that has to be taken into consideration. This process of claim adjudication on this is they are always important, that this is especially important.

My time has expired, and I will yield back. But I thank you all.

Mr. RUNYAN. I thank the gentleman.

The chair now recognizes the gentleman from New York, Mr. Turner.

Mr. TURNER. Thank you, Mr. Chairman.

And I would like to thank the panelists.

I have one question for Ms. Perkio. You mentioned advocates to help negotiate or navigate people through this bureaucratic maze and through the legal system.

Could you give us a little more on that, what you have in mind, how that might work? Where would you get these people?

Ms. PERKIO. The American Legion has 2,000 accredited American Legion service officers who are trained in assisting veterans in all types of claims. And we provide training twice a year for our service officers. There is no fee to work with an American Legion accredited service officer.

I myself have been accredited and we are given training both from the VA and through The American Legion on how to, and through VHA, on how to handle claims. So just understanding the process and working with claims, working with senior veteran service officers.

For instance, the process that I went through, you learn something new on every claim and every MST claim is going to have another element. And working with behavioral health has a big im-

pact on how that claim is going to turn out so that that behavioral health provider understands what they need to do to support that veteran's claim as well.

And that is where in my testimony, if the VBA would be more transparent in what they were really looking for in their information, for instance, on the letter from the medical professional that says that this is a nexus statement, that it is due to military sexual trauma, to know that the VBA wants to review all those documents in order to be an informed professional to write that letter and that they will not accept a statement just on the veteran's hearsay.

And our service officers are well trained in that. All of our service organizations, actually the DAV, VFW, we all have service officers who will assist those veterans free of charge in filing claims. And so there is help available without going to an attorney.

Mr. TURNER. And how does the process start? Does the VA make the connection between a claimant and an advocacy group such as yours?

Ms. PERKIO. Typically a nurse case manager will be involved and they have a list of the service organizations that may be available right in the regional office next to them. And they will allow that servicemember to choose which service organization they may feel that they would like to work with.

And so that referral process has worked very well in the past and that service officer will come in. And sometimes they will interview each department service officer with each organization to determine how well they fit with that.

The credibility and the empathy and the understanding that goes with a claim regarding MST is going to go a long way in the trust that that person will put with you. They have to repeat that story not only to their medical care provider, but they repeat that story to that service officer and then the service officer will tell that veteran this is what we are going to do for you and this is what we are going to need. And that kind of helps that situation along.

It is the servicemember who does not have an advocate that is really going to struggle and to meet a lot of road blocks. And being able to work with behavioral health makes a big difference.

Mr. TURNER. Is the VA obligated to provide an advocate or——

Ms. PERKIO. No, the VA does not provide an advocate. But in their letters, they will advise the veteran that there are advocates available and will give a list or a Web site that they can go and look to find an advocate for them.

Mr. TURNER. So all they do is dispense the advice on maybe how to best navigate this by contacting American Legion or——

Ms. PERKIO. Correct.

Ms. ILEM. And it also depends on if you are talking about within VHA or VBA, but VHA does have military sexual trauma coordinators in each of its medical facilities. And oftentimes veterans do work directly with them to talk about how they can pursue their case, you know, for claims.

And they may be referred to someone in a regional office. They also have that equivalent of a military sexual coordinator. So those people should also be able to provide that additional information if they want to have a veteran service organization assist them.

Mr. TURNER. All right. My time is up. Thank you.

Mr. RUNYAN. I thank the gentleman.

Mr. TURNER. Yield back. Thank you.

Mr. RUNYAN. The chair now recognizes the other half of the Maine delegation, Ms. Pingree.

Ms. PINGREE. Thank you very much. I really appreciate the opportunity to be here with your Committee and also to sit on my fellow delegation Member's Committee for a few minutes.

But thank you very much, Chairman Runyan and to Ranking Member McNerney, both for holding this hearing and for everyone on this Committee's very thoughtful questions and being willing to take on what I think is an extremely important issue.

I want to make just a couple of comments and then I have some questions as well.

I think generally the VA is doing a good job providing counseling and treatment to victims of MST, but when it comes to awarding benefits, as we have heard so much already today, MST survivors face tremendous roadblocks and bureaucratic red tape.

Since most attacks, as we have heard, go unreported, it is very hard for victims to provide the documentation during the claims and therein lies some of the source of our problem here.

The current policy states that they will be very liberal in deciding MST cases and should accept secondary markers as the proof that the assault occurred, things like counseling reports for PTSD from MST, letters from family members citing behavioral changes, drug and alcohol abuse, but it has been our experience in my office that this policy is not being followed.

The VBA remains vastly inconsistent when deciding on MST cases and what one regional office accepts, as we heard earlier, accepts as a secondary marker, another might deny and still not be violating VBA policy.

I think we have to be sure that VBA gives MST survivors the benefit of the doubt, especially when so many of these survivors have lost faith in the system they swore to uphold.

That is why I introduced the bill that you were asking about earlier and I appreciate the Chairman signing on to that bill. Basically it would provide service-connection for MST survivors if they provide a diagnose of PTSD and a medical link stating that the PTSD is caused by the assault similar to the policy now in place for combat related PTSD claims.

I want to be clear about this. The bad guy in these stories are the perpetrators. They are the villains and the ones who should be held accountable. But by creating this policy that denies justice to the victim and forces them to spend years or even decades fighting for the benefits that they deserve, we are deepening the wounds for those veterans and making it much harder for them to get on with their lives.

Ms. Bhagwati, thank you very much for your wonderful work and being here today.

And thank you to everyone on the panel.

A couple of questions. You have already talked a little bit about this very issue of the VBA and how it is working.

Do you think it is enough to ease the PTSD evidentiary burden for MST claimants or do you think we also need to ease the burden

for other common conditions associated with MST like depressive disorders and other anxiety disorders?

Ms. BHAGWATI. As I said in my testimony, according to the Veterans Affairs Department, PTSD is the most common mental health condition associated with MST, but depressive disorder and other anxiety disorders can be just as life threatening. And we certainly know that from the rest of the veterans' community.

Many combat veterans are also suffering from depression rather than post-traumatic stress. So, no, it is not enough just to focus on PTSD. We have veterans committing suicide every day from major depressive disorder and other very, very serious conditions and very common conditions.

Ms. PINGREE. Either of the rest of you would like to answer that or talk about that?

Ms. ILEM. I would agree. I mean, those are certainly other factors, mental health conditions that we see associated with MST related incidents.

Ms. PERKIO. In addition, all of the characteristics, anxiety, depression, those are all part of the PTSD criteria and so they should all be looked at because you never know when that claim may eventually be granted as a PTSD claim.

Ms. PINGREE. Thank you.

Ms. Bhagwati, you also had mentioned that rape mythology when you talked about this earlier and the VA's fear of fraud. It is my impression that fraud is likely to be low in a situation like this. As you have reported and others have, very few people come forward to talk about a rape, a sexual assault, a sexual harassment because of the implications of doing that.

But can you talk a little bit that since that is one of the reasons that we understand we do not have a better process here? Is there data to back it up or how can we sort of get rid of the mythology here?

Ms. BHAGWATI. The VA interestingly had the same concerns when it was debating whether or not to change the regulations related to combat and then the language ended up being about fear of hostile military or terrorist activity.

But the VA had that discussion after the regulatory change and decided that there would not be any false allegations or false claims as a result of this regulatory change. And I think the same thing can apply to this MST change.

We have looked through VA claims data. What often happens as a result of these mistakes, the first kind of rejection phase, is that the veteran, if they can tolerate it will appeal. Ultimately after a very, very lengthy appeals process or the very end of the phase, VA will reverse the decision and end up sort of siding with the veteran, but that can take years if not decades.

Why not just get it right the first time and give the veteran the benefit of the doubt and just simplify the system?

According to the FBI and numerous other agencies and studies, only two to eight percent, again, two at the low end, eight percent at the high end, of rape allegations are so-called false allegations. That is a very low percentage.

I would like to think that VA, is rooting for the 92 to 98 percent of rape and assault survivors that are telling the truth and, who

have investigations that can prove that they are telling the truth. That is all that that means. False reporting represents a very low percentage and is pretty much on par with other false allegations of crimes.

Ms. PINGREE. I have 30 seconds. Either of the other two of you like to say anything that was not covered about this?

Ms. ILEM. I would just note DAV also, you know, has spoken to or consulted with clinicians that have had a long history of treating, especially in VA, for treating military sexual trauma issues.

And we had the same sort of, you know, discussion that, you know, there may be a handful of cases in their career of 30 years where they really feel that, you know, they cannot really come forward, to feel that, you know, that that was a truthful statement.

But in the majority, the overwhelming majority of cases, they do. I mean, it takes a lot of commitment to come forward, to seek treatment, to have a diagnosis, and generally you have these long-term treatment records available, you know, that are consistent with an assault occurring.

Ms. PINGREE. Thank you. I am out of time, but thank you very much.

Mr. RUNYAN. I thank the gentle lady.

And on behalf of the Subcommittee, I want to thank each of you for your testimony and your service to our Nation's veterans. And with that, you are all now excused.

And I want to invite the second panel to the table. Among our guests on the second panel today is Dr. Barbara Van——

Ms. VAN DAHLEN. Dahlen.

Mr. RUNYAN. —Dahlen, the president and founder of the Give an Hour organization which encourages doctors to volunteer their time to help victims of military sexual trauma. And we also welcome Ms. Margaret Middleton, the Executive Director of Connecticut's Veterans Legal Center, which works to seek justice and proper benefits on behalf of victims of military sexual trauma.

Ms. Van Dahlen, you are now recognized for your oral testimony for five minutes.

STATEMENTS OF BARBARA VAN DAHLEN, EXECUTIVE DIRECTOR, GIVE AN HOUR; MARGARET MIDDLETON, EXECUTIVE DIRECTOR, CONNECTICUT VETERANS LEGAL CENTER

STATEMENT OF BARBARA VAN DAHLEN

Ms. VAN DAHLEN. Thank you for this opportunity to provide testimony regarding the issue of providing and improving access to care for veterans who have been sexually assaulted while serving in our military. It is an honor to appear before this Committee and I am proud to offer my assistance to those who serve our country.

Over the past several months, we have seen an increase in the attention given to a very serious issue affecting our military community, military sexual assault.

Understandably this type of attack and betrayal often leads to the development of severe mental health difficulties for the men and women who are victimized.

And as we have heard, many of the female veterans treated by the Department of Veterans Affairs and other programs receive a

diagnosis of military sexual trauma and this type of trauma is now the leading cause of post-traumatic stress disorder among female veterans, but it results in many other mental health issues as well, now surpassing combat trauma.

In addition, the experience of military sexual assault increases the likelihood of other serious and devastating conditions and consequences such as substance abuse, homelessness, and suicide.

While this issue is getting significant attention today, sexual assault has been affecting and often destroying the lives of those who serve for decades.

As I began to prepare testimony for this hearing, I had occasion to speak with a colleague who devoted over 20 years of service to the military. He continues to serve as a civilian with the Department of Defense.

I happened to mention to him that I was invited to testify before this Committee on this important topic. After stating that he was about to share something with me that he had never shared with anyone, not even his wife, he told me the following story.

He enlisted in the military at the age of 17. It was the late 1970s. Within the first year of his service, he was sexually assaulted by two men with whom he served as part of an initiation process.

He was humiliated and devastated. He told no one. He said there was no one to tell. Reporting would have made my life much worse. The stigma would have further damaged me and my career. I felt overwhelming guilt and shame.

This veteran suffered the consequences of the attack psychologically and physically for years. At one point, he contemplated suicide and went so far as to put all his affairs in order and make arrangements for the care of his two-year-old daughter and young wife.

His marriage fell apart and he and his wife separated. Fortunately, this veteran found help, repaired his marriage, and healed psychologically, though he continues to have significant physical problems that stem from the attack that shattered his life 30 years ago.

He shared his story with me now because he wants the Members of this Committee to understand that servicemembers who are sexually assaulted are unlikely to report the assault to their command, to their peers, to anyone. And you cannot often tell from looking at them that they have been affected, not for years.

We in the mental health profession know that it is critical for victims of sexual trauma to seek and receive assistance, support, and treatment as soon as possible. We also know that it is likely that many who suffer sexual attacks within the military will not seek care while they continue to serve.

We must, therefore, ensure that all of those who seek services through the VA for sexual assault once they leave the service are treated as quickly and as supportively as possible by allowing trained mental health clinicians to determine the veracity of a veteran's claim of sexual assault.

The signs and symptoms are well-known and VA mental health providers have already been given the appropriate responsibility

for making this type of determination regarding reports of combat stress injuries.

Moreover, given the humiliation survivors of sexual assault contend with, it is highly unlikely that many women or men will fabricate stories of military sexual trauma in order to receive VA benefits.

In addition, the lives that are saved by adjusting the process by which victims of sexual assault can qualify for and receive services through the VA will far outweigh the very few cases that beat the system.

In addition to changing the process for victims of sexual assault to apply for and receive services through the VA, we should continue to expand the network of providers available to meet the growing needs of the military community at large.

The VA has made tremendous strides in recognizing that partnerships with community-based organizations are critical if we are to provide the mental health services that the men, women, and families who serve our country need when they come home to our communities.

The VA recently signed an MOA with my organization, Give an Hour, which provides free mental health services to military personnel, veterans, and their loved ones. This MOA will facilitate appropriate referrals to our providers from the VA's veterans crisis line.

It is easy to imagine how community-based efforts such as those provided by Give an Hour and other organizations can assist the VA in their efforts to provide swift and effective care to those who have given so much to our country.

Thank you so much.

[THE PREPARED STATEMENT OF BARBARA VAN DAHLEN APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you, Dr. Van Dahlen.

Next we will hear from Ms. Middleton.

You are now recognized.

STATEMENT OF MARGARET MIDDLETON

Ms. MIDDLETON. Chairman Runyan, Ranking Member McNerney, and Members of the Subcommittee, thank you very much for asking me to testify about the VA disability compensation process for victims of military sexual trauma.

My name is Margaret Middleton. I am the Executive Director and Co-Founder of the Connecticut Veterans Legal Center. Our mission is to help veterans recovering from homelessness and mental illness overcome barriers to housing, health care, and income.

I am also a visiting clinical lecturer at Yale Law School and I coteach at the Veterans Legal Services Clinic there.

In both of those capacities, I work with veterans seeking VA compensation for PTSD caused by sexual assault in the military.

There are several experts at this hearing from the last panel who testified about the military culture, the extent of sexual assault in the military, and the scope of the VA's failure to assist those victims.

Rather than repeat that testimony, I would like to share some personal experiences I have had helping veterans confront the evidentiary standard of 38 CFR 3.304(f)(5) which is the current standard.

In my teaching capacity, I co-supervised a team of students who helped a female marine establish service-connection for PTSD stemming from a rape at Camp Lejeune in the early 1970s. At that time, she was 18 years old and extremely proud to be serving in the marines.

She was out drinking at an NCO club where she was not supposed to be and the acquaintance who was walking her home pushed her through a window and raped her in an empty barracks room.

This veteran felt tremendous shame and personal responsibility for having been out at night, for having been drinking, for having trusted the wrong person. She feared her romantic partner would leave her if she talked about the rape.

And her assailant who bragged about his conquest caused the warrant officer she considered sort of a father figure to tell her that she was the reason why women should not be allowed in the military.

This veteran was plagued for PTSD for decades following this assault and was diagnosed and is currently treated by a VA doctor for PTSD.

Assisting this veteran get connected for service-connection was incredibly complicated. Her parents had died. Her marriage had failed. There were no surviving letters of hers, no journals, no court records. She had lost contact with anyone she had served with 30 years earlier. She had been too ashamed and afraid to seek medical help at the time. Mental health treatment then was even less common and more stigmatized than it is now.

She was not demoted. She did not seek a transfer. She just continued to do her job and was honorably discharged from the marines.

Under the current standard, it took hours of work by two incredibly talented Yale students and an unusually cooperative VA physician to build her case based on what meager contemporaneous evidence they could sort of scrape together.

Almost no veteran has access to this kind of support and representation and they should not have to.

Another option might have been an independent forensic psychiatric evaluation that would have cost several thousand dollars that my client did not have and VA does not pay for.

This veteran's lack of documentary evidence is the rule and not the exception in these types of cases.

I recently interviewed a female veteran who was raped by two sergeants in her barracks 30 years ago. They ordered everybody else out and they kept her behind.

Decades later, similar to what the doctor just said, I was the first person that she had ever told. She did not tell anyone at the time because it would have meant the end of her career. And if you think her career was not important to her, she served in Iraq. She achieved the rank of master sergeant and she was retired honorably after 28 years serving in the military.

This incredibly strong soldier held back tears when she told me the story and it was only one of the several episodes of MST that she described to me.

This veteran's claim faces an almost impossible evidentiary burden because of this particular provision. She did not tell anyone what happened, so there are no medical records, no letters home, no actions taken against her assailants.

In order to succeed in the army, this veteran felt forced to stay silent and now she will be punished for her silence because the VA will refuse to credit her story based on her testimony alone.

As her advocate, it will take me and my team hours of phone calls to family members and old friends, combing through service personnel records, and begging doctors to provide a free forensic psychiatric evaluation to support her claim.

This is surely not what the VA anticipated when it adopted Section (f)(5), but it is the reality of how this provision is working in practice. We know that this is grossly unfair. We know how to fix it.

The VA can and should remedy this situation by amending the section to provide victims of military sexual trauma the same benefit of the doubt that other veterans are already afforded who seek compensation for PTSD.

There is no excuse for permitting the current regulation to stand and I hope this Subcommittee exercises its responsibility to America's veterans by correcting this injustice. Holding this hearing is a really important step towards change.

And I thank you again for the opportunity to testify and I would be happy to answer any questions.

[THE PREPARED STATEMENT OF MARGARET MIDDLETON APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you very much.

And, again, both of you, thank you for coming today and sharing your testimony with us.

Doctor, I have a question. It is actually two questions for you.

In your written testimony, you stated that despite the cultural differences between military and civilian life, the symptoms of sexual trauma are consistent and easily identifiable by mental health professionals.

Accordingly, you suggest VA should expand the network of qualified mental health specialists to assist the veterans who are victims of MST which in turn will assist VA claims processors review of the evidence in such claims. And now the two questions: how do organizations like yours become involved in this process?

Ms. VAN DAHLEN. Mm-hmm.

Mr. RUNYAN. And do you believe that having such access to an expanded network of mental health providers will encourage more victims of MST to come forward and report what has happened to them?

Ms. VAN DAHLEN. Absolutely, to the second question. I think we have already seen through, and our network now has provided 57,000 hours of free mental health care to servicemembers, veterans, and their families. It is an option outside the VA, outside DoD, that many desperately need and want for a variety of rea-

sons. So expanding the opportunity for victims of military sexual trauma to seek a provider in their community who would then be able to provide that confirmation of the military sexual attack would, I think, bring many more victims to be able to receive services and benefits. It is an issue in discussion right now, and has been for quite some time, regarding Post-Traumatic Stress in general. That currently only VA clinicians are allowed to provide that assessment. But there are many who believe that opening that door and allowing community-based mental health providers to provide expertise in areas that they are fully capable of making that diagnosis and assessment would assist in providing care, would assist in moving the process along more quickly in terms of benefits, services, etcetera.

Mr. RUNYAN. I remember, and I know many of the other Members who are here do also, when Secretary Shinseki sat in that exact same seat a couple of months ago saying our capacity to deal with the mental health issues we have in the VA, we are behind the ball on it. And it was a challenge that day to say, well, what is the number? How serious is the issue? And this is another unfortunately prime example of it. We do have the get a grasp on it. And if organizations like yours are an avenue to do something like that, I would hope that the VA would be open to something like that. Because it is a problem that we do not really know the magnitude of and what the sheer numbers of it are going to end up being.

Ms. VAN DAHLEN. I think that is absolutely right. And I would say that there has been tremendous progress. And I am very optimistic. Because up until a few months ago we were really working separately. Even though we had been there for several years now, since I began this organization seven years offering services. And they were happening. But it was only until very, very recently that we have now formed the first little step in an official relationship. And we are very optimistic. Because the numbers are very clear that this is, many refer to it as, you know, a tidal wave, a tsunami. There will be more and more of those who come home who are in need of assessment, treatment, support. Not just for themselves, but their families. So I agree completely. And I believe we are moving in the right direction. But as this issue gets more attention then more, which is a good thing, of those who have been assaulted will step forward. Which will create more backlogs within the VA. So again, I totally agree we need to move in that direction and hopefully we will.

Mr. RUNYAN. Thank you. Ms. Middleton, can you elaborate a little on some of the frustrations you have experienced dealing with the VA as an advocate on behalf of the victims?

Ms. MIDDLETON. Sure. Absolutely. I think the, our experience at the Connecticut Veterans Legal Center is that the way the regulations look on paper and the way they get used is very different. And that is why I really hope that the leadership here will use their bully pulpit to push the VA to change this regulation. Because it is not enough to say just bring in some extra documentation, what is the big deal? There is no reason why these veterans should be required to produce documents that other veterans do not have to. There is no, I cannot understand any reasonable expla-

nation for that. And so it actually seems like kind of an easy fix from my point of view.

Mr. RUNYAN. Thank you. And with that I will recognize the Ranking Member, Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman. I want to thank both of the panelists here for their volunteer efforts in this issue. And not only you panelists but the organizations that you represent. It is a lot of work and it is not easy work. So thank you very much.

Dr. Van Dahlen, what is your view of how well the military sexual trauma coordinators are doing? Is this an effective program?

Ms. VAN DAHLEN. Well I think that what we have seen over time, and again this is the good news, there is more and more that is happening that is working well. But the problem is so large and the VA system is so vast that it is as, it is the case with many issues. Not only military sexual trauma but other situations, combat trauma that result in Post-Traumatic Stress. It depends very much on the leadership in that particular region. It depends on that particular person. So we hear very mixed reviews. That in some areas it is working very well and in others not so much. And I think again it is about coordination of services. It is about leadership. It is about coordinating with organizations like ours so that we have more conversations that are happening. So I think the answer is good news that in fact they now exist, but we are not there yet.

Mr. MCNERNEY. Well what in your opinion would be the biggest barriers to determining appropriate VA services to MST victims?

Ms. VAN DAHLEN. Well I think the biggest barrier right now is what we have been talking about today. That there is not any reason to require—and here is another issue that we sort of talked about but I want to make very, very clear. For a large number, especially this is a way that military victims are in some ways perhaps different than civilians, the men and women who serve, they are so dedicated to their service. They want to stay in the service. They want to maintain their focus on mission. We may not be able to find evidence of behavior change, even if we have the best detectives on the planet going back and looking at, well, what else was happening to them at that period? Can we find it in their employment records? Can we ask other members of their community did you see a change to verify, to validate? You will not be able to find that. And so requiring them to provide some kind of evidence is contrary to the reality of who these men and women are. And that is a huge barrier.

Mr. MCNERNEY. Ms. Middleton, one of the things that interested me about your testimony was that you are advocating regulatory change as opposed to legislative change. Why does that make more sense to you?

Ms. MIDDLETON. I would love to see victims of MST get the compensation they deserve. And whether that requires an act of Congress or it requires the VA to change their own rule is not really of importance to me. I mean, however, however these folks receive justice is going to be great.

Mr. MCNERNEY. But I mean, in your opinion it could be done purely regulatory?

Ms. MIDDLETON. I mean, my understanding is that the VA promulgated this regulation in the first place. So they could change it. But I do not see why given the opportunity Congress would not fix this problem.

Mr. MCNERNEY. Well it was clear from your description of the case in Camp Lejeune that the soldier had few options if she wanted to remain in the military. She faced big obstacles, monumental obstacles really. Would you, how would you compare that experience to what somebody in the service would experience today? Is there any improvement?

Ms. MIDDLETON. I mean, the two veterans who I spoke about, one of them, I mean both of those instances I described were quite old. One of these veterans was discharged not that long ago, because she had such a long career in the military. And she described a later episode of MST that was very similar to the extent that she was completely unable to talk about it without jeopardizing her career. And I think that Dr. Van Dahlen summed it up very well. There is no incentive for these people to talk about this in the context of their work environment. And there is no reason that we should expect to see some kind of reflection of this in their personnel file. Which really makes, it really reflects the fact that this regulation reflects a misunderstanding about the way military sexual trauma actually works.

Mr. MCNERNEY. Okay. So we have quite a bit of work to do yet then. Thank you. I yield back.

Mr. RUNYAN. I thank the gentleman. The chair now recognizes Ms. Pingree.

Ms. PINGREE OF MAINE. Thank you very much, Mr. Chairman. Thank you both for your testimony. And I concur with my colleagues here, I really very much appreciate the work that you are doing and the assistance that you and your organizations give to so many people who need our assistance who frankly should not have to be in the position where they require such complex assistance. And I hope we can fix that.

I will ask this question of both of you. We see many denials where the VA states that the veteran could not be service-connected because they were sexually assaulted prior to their military service. VA examiners tell them their condition is related to the earlier assault, not the one that occurred in the military. I think that for these veterans a service assault would at least aggravate a preexisting condition but it seems like an inappropriate way to look at it. Do you see these types of denials in your work? And do you have comments about them?

Ms. VAN DAHLEN. Yes. And unfortunately one of the things that happens with victims of sexual assault is they, if that sexual assault is untreated they are more likely to be victims again. And so to say that because a man or woman was sexually assaulted before they entered the military, somehow then the psychological damage that we are seeing is not related to the additional assault, makes no sense psychologically. It makes no sense. It is like it is almost the, in fact it is, the opposite logic that we use for combat stress. Combat stress, we understand, we know this, the more deployments, the more exposure to trauma, the more significant the psychological damage. We have kind of gotten that right, finally. But

here we are saying the opposite. It makes no sense psychologically in any way. And in fact we know that victims are more likely if gone, if they are untreated, to become victims in the future.

Ms. MIDDLETON. I would say I have almost never spoken to a veteran who reported to me an incident of military sexual trauma who did not also experience some kind of trauma prior to entering the military. It is very, very common in my experience. And it is just one more reason why we should not hold the veterans to this unnecessary evidentiary standard. Because we do not need to muddy the water for the VA RO folks who already apply the rule pretty haphazardly.

Ms. PINGREE OF MAINE. Any other specific patterns of denials that you see, besides some of what we have discussed today? Obviously you are looking at a lot of different situations.

Ms. VAN DAHLEN. Well, I would like to just go back to the question that was asked about how prior generations, how much different is it today? I would say not that different, not in terms of the reports that we hear. And one thing again that has changed, which is good news, there are many, many in the Department of Defense who are outraged and coming forward. Men and women both who tell me that they have witnessed in their own units, these are leaders who will say that they see now signs. And sometimes that they feel like they are, that the system has not caught up quite with the change that is happening in the culture. So men and women are still faced with, and it is, combat stress, the impact of combat stress is slightly different. I think that curve we are kind of getting a little bit closer to more acceptance and support. But this one is even further behind the curve. But at least there are men and women in the Department of Defense, many, many clinicians in the VA, who would say, you know, we know, we know what we are seeing, we know what we are looking at, we can diagnose this. That is the good news. But in terms of the obstacles for reporting, and the way that women and men are often treated when they do report, very similar stories for this generation as well.

Ms. PINGREE OF MAINE. That is very discouraging when you think about how we feel our culture has moved forward. Yet that somebody who experienced this 30 years ago might have the, someone else might have a similar experience today. Did you have a comment, Ms. Middleton?

Ms. MIDDLETON. Only that we see veterans applying for compensation who are denied in all kinds of areas. It just happens to be that for claimants who are applying for PTSD connected to military sexual trauma there is an extra burden that as advocates we are really disheartened by. Because it creates a tremendous amount of unnecessary work and time away from other veterans we could be helping.

Ms. PINGREE OF MAINE. Great. Thank you very much. Thank you, Mr. Chair.

Mr. RUNYAN. On behalf of the Subcommittee I would like to thank you both for your testimony and all that you do to support our veterans. And with that you are dismissed.

Ms. VAN DAHLEN. Thank you.

Ms. MIDDLETON. Thank you.

Mr. RUNYAN. I would now like to welcome our third panel to the table, Ms. Ruth Moore, who is an extremely brave woman here today to tell her story about the military sexual trauma she experienced and her fight to obtain VA benefits. Ms. Moore is accompanied by her husband, Mr. Alfred "Butch" Moore, Jr. Ms. Moore has been working with Representative Pingree and I now turn to my honorable colleague for any remarks she might wish to make.

Ms. PINGREE OF MAINE. Well, thank you very much Mr. Chair. Let me just give another brief introduction and thank Ruth Moore and her family, her husband and her daughter, for joining us today. She is a MST survivor who fought the VBA system, as we are about to hear, for many years before she was finally service-connected. They made the long trip down from Maine. And I want to correct the record here, I share, I share Ruth Moore with Congressman Michaud. She actually lives in his district. But we were able to speak with her soon after we introduced the piece of legislation and have been happy to be in contact with her really appreciated her telling her story.

For 25 years Ruth has had to battle with the Navy, the VA, and frankly her own memories. I do not think many of us can truly appreciate all of what she and her family have been through. And I totally appreciate how brave she is to come with us today and tell her story. It is not an easy thing to do. But I think Ruth would say she knows if she keeps silent, and if all of the survivors of MST are silent, the problem will never go away. I appreciate your courage in coming here today. And I want to add one last thing.

Our local newspaper wrote a story about Ruth last week. And when the reporter asked her her biggest fear about testifying she said that they will hear my words but will not understand the depth of it. Well I want you to know you are in good hands. This is a Committee that cares deeply about this issue. I appreciate your holding the hearing today, and I appreciate you inviting Congressman Michaud's and my constituent to join us today. Thank you very much, Ruth.

Mr. RUNYAN. I thank the gentle lady. And with that we will recognize Ms. Moore for her testimony. You are now recognized.

STATEMENT OF MS. RUTH MOORE, CONSTITUENT WITNESS; ACCOMPANIED BY ALFRED "BUTCH" MOORE, JR., HUSBAND TO RUTH MOORE

STATEMENT OF RUTH MOORE

Ms. MOORE. Thank you. Good afternoon, ladies and gentlemen. My name is Ruth Moore and it is an honor to be among you today. As you know, I am a military sexual trauma survivor who lives with PTSD and depression. I am here today to share my 23-year struggle to get help from the Veterans Health Administration and disability compensation from the Veterans Benefits Administration.

In 1987 I was a bright, vivacious 18-year-old serving in the United States Navy. After my training school my first assignment was to an overseas duty station in Europe. Two and a half months after I arrived, I was raped by my supervisor outside of the local club, not once but twice. I sought help from the chaplain but did

not receive any. I tried to move beyond this nightmare but had contracted an STD.

At this point my life spiraled downward and I attempted suicide. Shortly thereafter I was MedEvac'd to Bethesda Naval Hospital and ultimately discharged from the Navy. No prosecution was ever made against my perpetrator. In hindsight it was easier for the military to get rid of me than to admit to the rape.

My problems began at the point of separation as the psychiatrist diagnosed me with a borderline personality disorder. I did not have a borderline personality disorder. This was the standard diagnosis that was given to all MST survivors at that time to separate them from active duty and to protect the military from any and all liability. This travesty continued and I was counseled by outprocessing to waive all claims to the VA as I would get health care through my former spouse, who was on active duty.

From 1987 to 1993, I struggled with interpersonal relationships, could not trust male supervisors, and could not maintain employment. I filed my first VA claim in Jacksonville, which was denied despite having several markers for PTSD and gynecological issues. My life continued to spiral downward and I was not able to maintain my marriage. In 1997 I fled from my house and lived out of my van for two weeks before I was able to start rebuilding my life with my present spouse. Things were very difficult and I developed additional markers of PTSD, including night terrors, panic attacks, severe migraines, and insomnia.

In 2003 I filed for disability and was denied again. However, I enlisted the aid of the Disabled American Veterans. With their help I was awarded 30 percent compensation for depression. I was denied PTSD and was told that I did not submit enough evidence to prove that I was raped, despite having submitted a letter from my former spouse who remembered the rape and the chlamydia. Given this eyewitness testimony, the VA still denied this as credible proof. There was no record of my medical treatment for STD from that duty station as my medical records had been expunged. Additionally, I was coded by Togas VA as having a traumatic brain injury or brain syndrome.

In 2009, I entered into my first comprehensive treatment at the VA hospital in White River Junction, Vermont. I met an MST coordinator who truly listened to me. She began a systemic review of my records and determined that they had been expunged, by noting the glaring inconsistencies between my lab work notes and service record. My psychiatrist and counselor determined that I did not have borderline personality disorder, nor traumatic brain syndrome. My MST coordinator and I refiled for an increase in disability and my clinicians wrote supportive records for the VBA to make an accurate determination. They readjudicated my claim to 70 percent but denied my status as individually unemployable, citing that I did not complete the necessary paperwork.

At this point I was very frustrated and suicidal with the stresses of the VBA system and claims process. In my final effort, I called the Honorable Bernie Sanders and his staff agreed to investigate why the VA was taking so long and denying my claim. I took Mr. Sanders copies of all the paperwork I had filed, including the VBA time and date stamped missing information. Within two weeks my

claim was finally adjudicated to 70 percent with IU and it was total and permanent. My rating should have been 100 percent by the VBA criteria, but I was so grateful for a favorable determination that I have not pursued it.

Ladies and gentlemen, this process took me 23 years to resolve. And I am one of the fortunate ones. It should not be this way. If I had been treated promptly and received benefits in a timely manner back at the time of my discharge, my life would have been much different. I would not have had to endure homelessness and increased symptomology to the point where I was suicidal. I would not have miscarried nine children. And I firmly believe that I would have been able to develop better coping and social skills. Instead my quality of life has been degraded to the point where I am considering the possibility of getting a service animal to relieve the stress that my husband endures as my unpaid caretaker. I am asking you, no I am pleading with you, to please favorably consider the legislation that would prevent this from happening to others.

Congresswoman Pingree's legislation is one way to change the burden of proof that is required to enable MST survivors to receive proper adjudication for MST and PTSD. Please do what is right. Support this legislation. It is urgently needed. And thank you for your time and audience today.

[THE PREPARED STATEMENT OF RUTH MOORE APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you very much, Ms. Moore. And we truly do appreciate you being here. Once you volunteered to serve our Nation through the armed services, but you being here today and continuing to share your story, you are continuing to serve by shining a light on this. Sharing your experience to us is only going to help us make sure that this does not happen to anyone else. And I know you have endured some horrific challenges, as you just discussed in your time in the military and in your personal life after that. And, I am kind of choked up. I just really again would thank you for being here today. I know working with Ms. Pingree on this piece of legislation is one of many steps we discovered here today, that we will look into.

If there is anything I or my colleagues can do, and this goes out to any veteran, do not ever hesitate to call us. Because that is truly what we are here for, is to serve you because of your service to this great Nation. I again thank you for being here. I know it is not easy to sit here and talk about something like this. And I am going to refrain from any questions that I might have. And thank you again for our testimony. And I yield to the Ranking Member, if he would have anything to say.

Mr. MCNERNEY. Well thank you, Mr. Chairman. Ms. Moore, Mr. Moore, thank you for serving our country. Thank you for taking that service enough to be here in front of us today. It is important to hear your testimony and your testimonial. And it will have an effect. We will do what is necessary. We cannot promise immediate change. But certainly, you know, having that in front of us and reminding us of how difficult life can be as a result of this sort of experience will remotivate us to work as hard as we can on this

issue. So I am not going to ask any questions. But I want to thank you for coming, and bringing your husband and your daughter.

Ms. MOORE. Thank you.

Mr. RUNYAN. Ms. Pingree?

Ms. PINGREE OF MAINE. Well thank you very much. And Ruth, I will thank you again, and to your family for being here with you today. It really does mean a lot and I really appreciate the chair and the Ranking Member for their sentiment. And I appreciate the Ranking Member for saying what I think is important to say. That you are serving your country twice today, coming forward and speaking here and providing us with another firsthand story about how difficult this situation is.

I will not torture you much. But I will let you just have the opportunity if you would like to speak a little more about the many markers. We have talked a lot today about the burden of proof and how we just put it back and back and back. And the number of times that you have gone through the process in attempting to resolve your own situation, which took an enormous amount of strength and determination and resolve to continue to go back and try to find the assistance that you needed. Can you talk a little bit to the extent that you would like to about the markers that you provided and how they were rejected?

Ms. MOORE. I would be happy to. The markers that I have. As it was addressed here, there are many markers for PTSD. Some of them are recognized, some of them are not recognized, and it all depends upon the clinician who is making the diagnosis. I am happy to say that over time the process has improved in the VA and we now have more capable and competent providers who are able to recognize these markers and make appropriate diagnoses. I am also happy to say that the general perception of the military is improving with respect to MST survivors. At the time that I was in it was an embarrassment to the command to have an MST case. The commanding officer did not want this to be a record on their, or a mark on their record for poor administration or poor leadership.

I think what it really boils down to is we need to have capable, competent providers who are trained to understand these things. I think the burden of proof that I submitted was credible proof. Having an eyewitness testimony being shot down and told that that was not credible proof to the VA was certainly very disturbing. It was documented and received in 2004, and it was mysteriously lost from my records. And then in 2009, Mr. Sanders brought it forward again because I had a copy of it. I was one of the few people that made copies of everything and kept them. Many people do not. Many people are told just move on with this. If you want to have a career you need to just forget this and move on. I was not so intelligent back then and I did not forget it, and I did not move on with a career. It was very hard for me. So I think that the markers that we have now are much better. And I think the legislation that you are proposing would make it much better for many veterans. Because, you know, we need to be believed and heard.

I would also encourage the panel to consider the fact that VA systems are different from region to region. I live in Maine now. I lived in Maine at the time. And I was denied in Maine. I was de-

nied in Florida. It was not until I reached the White River Junction VA Center that I actually found what an MST coordinator was. And I actually found out that what happened to me happened to other people. She was so sympathetic and she was so helpful. And the first thing she did was look at my record and she says, "Well this is missing, and this is missing, and this is missing." These are classic things that happen with MST cases. Their files are expunged. And to clarify for the panel, I will say that in a medical record the left side of the record is your lab notes, the right side of the record is your treatment record. And my record had been expunged so badly that things were missing out of one side but not the other. So it was like a great big puzzle without the pieces. And you could see part of the picture but not all of the picture. And then by the VBA standards that basically meant that nobody wanted to take the time to look, so I was denied.

Ms. PINGREE OF MAINE. Well thank you for providing that information. And I do want to add that while we are looking at the problems with the system today and the things that need to be changed, and many of the challenges that people faced, I do want to acknowledge that when you did encounter a competent and thoughtful and well trained MST coordinator who was able to be in the position to help solve your problem it was very useful. And, you know, we have many hardworking people at the VA who are struggling under a system that is in the process of change and often with a huge workload. So I do want to acknowledge there are times when you meet those people who really do offer you assistance in your life. And certainly Senator Sanders as well.

Just in closing, again, thanking you very much for your testimony here today. And I know you have talked a lot about the challenges that you have gone through. But I want to acknowledge your daughter Samantha who is in the room today. Who as I understand is getting a Girl Scout Medal of Honor this year, only the 21st person in America to receive one for many of her heroic acts. So you two are clearly wonderful parents and have done many great things in your life, and we are proud to have you in Maine.

Ms. MOORE. Thank you.

Mr. RUNYAN. With that, on behalf of the Committee I would like to thank you for your testimony, and thank you for your service to this country, and your continued service to our country. And with that, you are now dismissed. And I will invite the fourth panel to the witness table.

Today we welcome Colonel Alan Metzler, Deputy Director of the U.S. Department of Defense's Sexual Assault Prevention and Response Office; and we also welcome Mr. Tom Murphy, Director of Compensation and Pension Service for U.S. Department of Veterans Affairs. Mr. Murphy is accompanied by Ms. Edna MacDonald, Director of the Nashville Regional Office at the U.S. Department of Veterans Affairs. And Colonel Metzler, you are now recognized for five minutes for your testimony.

STATEMENTS OF COL. ALAN METZLER, DEPUTY DIRECTOR, SEXUAL ASSAULT PREVENTION AND RESPONSE OFFICE, U.S. DEPARTMENT OF DEFENSE; ACCOMPANIED BY DR. NATE GALBREATH, SENIOR RESEARCHER AND TRAINING ADVISOR, SEXUAL ASSAULT PREVENTION AND RESPONSE OFFICE, U.S. DEPARTMENT OF DEFENSE AND MR. THOMAS MURPHY, DIRECTOR OF COMPENSATION AND PENSION SERVICE, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MS. EDNA MACDONALD, DIRECTOR, NASHVILLE REGIONAL OFFICE, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF COL. ALAN METZLER

Colonel METZLER. Chairman Runyan, Ranking Member McNerney, and Members of the Subcommittee, thank you for inviting us to appear today. I am the Deputy Director of the Department's Sexual Assault Prevention and Response Office and my colleague is Dr. Nate Galbreath, the Senior Executive Advisor for Research and Training.

Let me begin by restating Secretary Panetta's bottom line on this serious issue. Sexual assault has no place in the Department of Defense. Secretary Panetta has put great emphasis on dealing with the crimes of sexual assault. It is an affront to the basic American values we defend and it is a stain on the good honor of our armed forces. Since our policy was instituted in 2005 we have remained committed to our vision, a culture free from sexual assault.

Our uniformed leadership is committed to driving this change. In May, the Joint Chiefs of Staff issued an unprecedented strategic direction signed by eight four-star leaders, including the Chairman and Vice Chairman of the Joint Chiefs, and the Chiefs of Staff of each of the military services, and the National Guard. This direction calls on the entire force to focus on four areas. Enhancing awareness; encouraging open communication and timely reporting; holding offenders accountable; and providing responsive victim services. Our goal is to create a culture that will not tolerate sexual assault.

While we are absolutely committed to combating and eliminating sexual assault from the armed forces, we remain acutely aware of the brutal facts that point to the challenges we face. Although the department received 3,100 sexual assault reports in 2011, offenses ranging from wrongful sexual contact to rape, our anonymous survey data suggests that in 2010 as many as 19,000 servicemembers were victims of some form of sexual assault. It remains unacceptable to us that we would have even one of these crimes occurring in our armed forces.

We have undertaken many enhancements to support victims, encourage reporting, increase the availability of documents for veterans. And I would like to talk briefly about some of those efforts. In February, 2011 we launched the DoD Safe Helpline, a worldwide 24/7 crisis support service for members who are sexual assault victims. To date, more than 47,000 unique users have visited that Web site, and more than 4,000 individuals have received live services. We are professionalizing our key positions that support victims by designing a Sexual Assault Response Coordinator (SARC)

and victim advocate certification program that will consist of credentialing that aligns with the National Advocate Credentialing Program.

In December the Secretary of Defense mandated increased retention for sexual assault documentation. For unrestricted reports, documents will be kept for 50 years, and this was specifically designed to allow transitioning servicemembers and our veterans who may desire to make a claim at a later date.

Also in December the Secretary created a new protection for victims. They now have the option to request a permanent or temporary transfer from their command or base, or to a different location within their command or base. Victims make the request to their commander, and they must receive an answer in 72 hours. If denied for some reason the victim may appeal to the first general officer in the chain of command.

I would also like to mention, Mr. Chairman, several new initiatives that will enhance prevention and accountability. In December the President signed an Executive Order that added a new privilege that protects communications between a victim and victim advocate, enhancing victim trust in the department's response system. Our sexual assault incident database has now gained initial operational capability. This tool will standardize reporting for oversight and accountability and it will help us manage victim care. For victims making an unrestricted report, the reporting form will be maintained in this database and it will be maintained for 50 years, a capability we designed into the system specifically for transitioning servicemembers.

To advance accountability, Secretary Panetta directed the initial decision on cases of rape, sexual assault, forcible sodomy, and attempts, they will be elevated to a commander who is at least a colonel or a Navy captain who holds special court martial convening authority. And this mandate became effective on June 28th and it ensures an experienced commander will make these important decisions.

In April, Secretary Panetta also directed several other new policies. Establishing special victim unit capabilities; requiring sexual assault policies be explained to all servicemembers within 14 days of their entrance on active duty; allowing Reserve and Guard members who have been sexually assaulted to remain in their active duty status to obtain treatment and support; and the requirement for annual organizational climate assessments.

Finally at the Secretary's discretion in May, we conducted a review of existing precommand and senior enlisted training in the Marine Corps, the Navy, and the Air Force, and we have reviewed the Army's new program as well. We completed our report last month. We have made recommendations to the Secretary and there are other additional oversight assessments ongoing, to include a review of our sexual assault response coordinator training and joint base assessments.

We also want the Committee to be aware of the work we have done to collaborate directly with the Department of Veterans Affairs. During the last two years our office has visited 20 VA facilities to provide education on our program. These sessions have been well attended by administrators, providers, and even patients. We

have also provided educational briefings to the VA's military sexual trauma coordinators, training hundreds on the specific elements of our program. Just last month we augmented our DoD Safe Helpline for transitioning servicemembers. This tool recognizes the special needs of victims of sexual assault and helps smooth the transition to the Department of Veterans Affairs. And while the hearing was going on, we did research and look into our Web site and I can confirm to you that we have links to the veterans service organizations that can help our members transition and we are open to adding many more.

Finally in its June, 2011 Veterans Benefits Manual, the Department of Veterans Affairs has added our Department of Defense reporting forms to help document a sexual assault.

Mr. Chairman, Members of the Committee, despite these many efforts we have much more to do. Secretary Panetta and our uniformed leaders are committed to creating a climate of mutual trust, respect, and dignity. We are committed to creating a climate in which victims feel confident that they will be believed, that their reports will be taken seriously, and that there will be no fear of retaliation. We are committed to creating a climate in which bystanders act to intervene. We are committed to providing the full range of services to all victims of sexual assault. We are committed to continue our work with the Department of Veterans Affairs to further improve victims' transition from active duty to veteran status. And most important, we are committed to ensuring that the discretion over how to report and decisions regarding treatment and support services rest entirely with the victim.

Through this approach we aim to create a culture that is intolerant of sexual assault, one that cares for our victims, one that inspires trust and confidence, one that encourages reporting, and one that enables our military justice system to hold offenders accountable.

We appreciate the Subcommittee's attention to this important issue and we look forward to your questions.

[THE PREPARED STATEMENT OF ALAN METZLER APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you, Colonel Metzler. I next recognize Mr. Murphy for his testimony.

STATEMENT OF THOMAS MURPHY

Mr. MURPHY. Good afternoon, Chairman Runyan, Ranking Member McNerney, and Members of the Subcommittee. I am accompanied today by Ms. Edna MacDonald, Director of the Nashville Regional Office and former Deputy Director for Policy and Procedures in Compensation Service. Thank you for inviting me today to speak about the VA disability benefit for PTSD based on MST and sexual harassment.

Over the last several decades women have entered the military in increasing numbers and now comprise a significant percentage of the veteran population. Associated with this growth, VA has seen an increase in the filings of PTSD claim based on MST. However, VA recognizes that both men and women can be victims.

Because of the personal and sensitive nature of MST stressors, victims find it difficult to report or document these events. Due to this fact, it is often difficult to establish the occurrence of the stressor. In order to address this, VA developed regulations and procedures that allow more liberal evidentiary development and adjudication procedures for this type of claim. Under VA regulations service-connection for PTSD requires three things. First, medical diagnosis of the condition; second, a medical opinion connecting current symptoms and an in-service stressor; and third, credible supporting evidence that the claimed in-service sterssor occurred.

As with all PTSD claims, VA initially reviews the veteran's military service record for evidence of MST. Such evidence may include a DD form 2910, the victim reporting performance statement, and the DD form 2911, sexual assault forensics examination report. VA's personal assault regulation also provides that evidence from sources other than a veteran's service records may corroborate the veteran's account of the stressor. This includes, but is not limited to, law enforcement authorities, rape crisis centers, pregnancy tests, tests for sexually transmitted diseases, and statements from family members, roommates, clergies, etcetera. Evidence of behavior change called markers is also used. Examples are request for a transfer, deterioration or hyper work performance, substance abuse, and so on.

When this type of evidence is obtained VA schedules the veteran for a C&P examination and requests an opinion as to whether the claimed in-service MST stressor occurred. This opinion serves to establish the occurrence of the stressor.

VA has recently taken numerous other steps to assist veterans with timely, equitable, and consistent resolution of these claims. In August 2011, VBA reviewed a statistically valid sample of approximately 400 MST related PTSD claims. The goal was to assess the current process and procedures and formulate methods for improvement. This led to development of an enhanced training curriculum with emphasis on standardized evidentiary development practices. VBA issued Training Letter 11–05, Adjudicating Post-Traumatic Stress Disorder Claims Based on Military Sexual Trauma, in December of 2011. This was followed by a nationwide Microsoft Live Meeting broadcast focused on describing the range of potential markers that could indicate occurrence of an MST stressor.

We recently created dedicated, specialized MST claims processing teams within each VA regional office for exclusive handling of MST related PTSD claims. VHA has developed and implemented specific training for clinicians conducting PTSD/C&P examinations for MST related claims in November of 2011. VBA and VHA further collaborated to provide a training broadcast targeted to VHA clinicians and VBA raters on this very important topic which aired initially in April, 2012, and has been rebroadcast numerous times.

The results of these efforts are substantial. The grant rate for PTSD based on MST when we started this effort in October of 2012 was 41.7 percent. Following the completion of the process changes and training outlined just a moment ago, we are seeing a steady grant rate of 53.9 percent for the period of January through June, 2012. Due to the significant change in the outcome for these veterans, we are sending each veteran that was denied prior to receiv-

ing a VA examination a letter notifying them of the opportunity to have their claim reexamined. VA will make every effort to ensure that the claimants receive the benefits they deserve and secure the maximum rating and effective date to which they are entitled.

In summary, VA recognizes the sensitive nature of MST related PTSD and the difficulty of obtaining evidence of an in-service sterssor. Currently PTSD regulations provide multiple means to establish an occurrence and VA initiated initial training efforts and specialized handling procedures to ensure thorough, accurate, and timely processing of these claims.

This concludes my testimony. I would be happy to address any questions from the Members of the Subcommittee.

[THE PREPARED STATEMENT OF THOMAS MURPHY APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you, Mr. Murphy. I have a group of questions and I am not sure if I am going to put them out there in the right order. But two years ago when VA amended 38 CFR 3.04(f) making certain claims for noncombat PTSD easier to verify, during the notice and comment period, several commenters asked that the amended regulation apply to MST. In response, VA stated that they did not feel this was necessary because the relaxed evidentiary standard already provided to the regulation specific for MST was adequate. We have had testimony earlier and having been briefed by the VA on this, I can imagine your stance. You feel that it is easier. But I think the users that are doing it do not have the same feeling, or the same experience. Is there any way you can clear this up? Because it is, in the statement and the comments, it specifically said it was outside the scope of the rule when VA made the comment back to the commenter about the issue. Do you have any idea how we can clarify this? And maybe we have to change the regulation to actually make it work for those who we are trying to help?

Mr. MURPHY. Mr. Chairman, I am going to ask Ms. MacDonald to address this concern. She has significantly more depth and expertise in this area.

Ms. MACDONALD. Thank you, Tom. Chairman, when we looked at the regulation based on Fear, there is this misunderstanding that we have heard so far in testimony today that, specifically a veteran's lay statement is accepted for all other forms of PTSD except MST. It is a slight misunderstanding. In other forms of PTSD we do require what we call objective documentation. Not just the fact that a veteran served in the military. But for combat veterans, before we can accept their lay statement, we have to have a military documentation that they were actually in a combat zone. For Fear, for that regulation, it also requires documentation that they were in an environment where there was hostile military or terrorist activity before you ever get to the lay statement. Why we believe that the MST regulation is a lower evidentiary threshold is that, because we know so many do not get reported, there is no requirement for any military objective documentation of occurrence of the stressor. That is why the regulation was written, to allow us to look for markers and other sources that are what we would call in the regular world, circumstantial evidence. That is not concrete

proof. And what we have heard today is what you were just talking about. Is it adequately being applied, that liberal threshold? And that is what Mr. Murphy was alluding to in his testimony that we do believe we have made significant strides to make sure that we dedicated resources and we trained VA employees properly in the way we want this and the way we expect it to be applied.

Mr. RUNYAN. Is amending the regulation necessary? I think Congressman Walz and Ms. Pingree both agree that, the chances of a false claim are very minimal in cases like this. Do we need to change the regulation to make sure this works for MST victims?

Mr. MURPHY. No, sir. I do not believe we need to do that. And I think when you look at the performance numbers of the grant rate of PTSD today versus the grant rate for all other types of PTSD that are not MST related, you see that the numbers track very closely. Now, I am not sitting here saying by any means that we have got this thing completely nailed down and its is perfect. There is no process on earth that is that way. So this is a process that we are going to continue to look at, and we are going to focus on, and continue to ensure that MST tracks at the same rate. In addition, we have heard many testimony on different ideas, different processes, different thoughts. And we will continue to gather those and look for ways to make the process even better and more consistent than it is today, so that no veteran is wrongly denied. But I do not believe we need to go back and do a regulation change in order to put that down and make it solid. I think the performance over the last six months is proving that we have consistency in process.

Mr. RUNYAN. And if you could, I am sure you do not have it on hand, but throughout, I know there has been reference to when the policy was changed and when VA revisited the regulations, which was in 2010. Because we have sat up here all day, we have heard that sexual assaults are underreported. And actually the execution of adjudicating the MST claim, we are not seeing the whole picture all the time. And I think this is the big frustration we have with the VA a lot of time. You are telling us what sounds good when you are sitting at that table, but we are not seeing the whole picture. Because I think most people, and the people who have been here and testified today, would agree that there is room for more improvement. And I think we all agree on that. The issue at hand is what are the improvements that we take in this Congress to do that? I think we all agree, and I think the Ranking Member agrees, we are not going to fix it today. But we have to get the ones that we can tackle the most with. And I would appreciate the statistics that say it was this way, and when we did the change in '10 we got better results. Maybe it is time to address that again because I think we all agree and we need different results. And I would appreciate it if you could submit that to the Committee.

Mr. MURPHY. Yes, sir. We will do that. We will take it back before the release in 2010 and we will point out the significant changes that happened in that data as the results of different actions that were taken from then to now.

Mr. RUNYAN. I appreciate that. And with that I recognize the Ranking Member Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman. Colonel Metzler, thank you for serving our country and wearing that uniform, and taking on this difficult issue. One of the things we are hearing today over and over is the reluctance of servicemembers to come forward because of the cohesion of the unit that they are in. And that is important. I mean, you want a military unit that can go into a difficult situation and trust each other, and that is a characteristic that is hard to nuture. So what happens to a unit when this sort of an issue comes up? Does it disrupt the unit? I mean, does the leader get disposed? Is there training that takes place in the unit? I mean, this is, if there is a unit where people are preying on each other, then you are not going to have unit cohesion anyway. So it does not hurt to go in and actually do some stuff to that unit. What happens when this kind of a charge comes forward and is verified?

Colonel METZLER. Good order and discipline, unit cohesion, a climate of trust and a climate of respect all come from the command and the leadership. And the effectiveness of a unit derives from the effectiveness of that commander and those senior leaders who set the appropriate climate, who set those standards, and communicate those standards, and enforce those standards. And when those standards are failed to be followed, the unit, cohesion breaks down, the mission is placed in jeopardy, and lives are placed in jeopardy, both in a combat environment and in a peacetime environment. And what we need to do is ensure that we teach every single member of our armed forces that if there is violence being committed against them, sexual violence being committed against them, that we will take those reports seriously, that we will investigate them fully, and that we will hold the offenders appropriately accountable.

Mr. MCNERNEY. So I take it there is an anonymous, a Web site a member can go to anonymously and make a report?

Colonel METZLER. There is a couple of tools available. There is the DoD Safe Helpline. It has been in operation since February of 2011. It is 24/7, worldwide capable. You can call, click, or text into that capability. And there are crisis——

Mr. MCNERNEY. Is the unit leader advised when there is a report from someone within their unit?

Colonel METZLER. The installation commander is advised of all unrestricted and restricted reports and the unit commander is notified for unrestricted reports. And then the commander is required by policy to report that to a military criminal investigative organization for investigation.

Mr. MCNERNEY. Okay. Are servicemembers routinely screened for MST?

Colonel METZLER. Sir, military sexual trauma and the screening and the diagnosis for that is outside the scope of our office's oversight. What we do know are the specifics in terms diagnosing military sexual trauma (MST). And so what we have done is built a structure to ensure that we have the records, to make sure that they are available, that our counselors know how to retrieve them. We have this 24/7 worldwide hotline that can access crisis intervention counselors who can advise them of all the processes associated with MST. And as I mentioned in my opening statement, we

have been doing a lot of partnership with the VA to train their military sexual trauma coordinators, and to train our coordinators that work with wounded warriors.

Mr. MCNERNEY. Well it sounds good. I would like to have confidence that it was being effective. Mr. Murphy, what do you feel about HR 930? Do you think that is going to make things better? Do you think that is going to make it so that people that are suffering and going through the experiences that Ms. Moore experienced, is it going to make it easier for them? Or do you think it is going to make it harder? Or do you think it is going to make a difference at all within the VA?

Mr. MURPHY. Mr. McNerney, that is a bill that we have not completed formal views on from the VA perspective, so I am not prepared to comment on that today.

Mr. MCNERNEY. So now, and my limited understanding is that H.R. 930 will result in reduced evidentiary standards. Is that what your understanding is of H.R. 930?

Mr. MURPHY. Yes. That is my understanding of the bill.

Mr. MCNERNEY. Is there a need to reduce evidentiary standards?

Mr. MURPHY. As I told Mr. Runyan a few moments ago, I think that we adequately cover it with the existing regulations that we have today. But that is not a comment on the nature of the bill. And the reason I say it is not a comment on the nature of the bill that we hit the main topic in it. As with most bills, they come through, there are many fine points and details in there that need to be considered by a general counsel in VA before we can pull an official position on it.

Mr. MCNERNEY. If that bill were to be signed into law, how difficult would it be to enforce its requirements?

Mr. MURPHY. Assuming the bill was signed into law, then it would just take us the time that it would take to put, to modify existing regulations to be in compliance with the requirements of the law, to put some training in place for the existing dedicated teams that we have inside of VA and in VHA, and start adjudicating claims under the new law.

Mr. MCNERNEY. All right. I yield back.

Mr. RUNYAN. The chair now recognizes Ms. Pingree.

Ms. PINGREE OF MAINE. Thank you, Mr. Chair. Thank you to the panel for testifying. I do appreciate the tremendous change in attitude and awareness that has gone on, both at the DoD and VA. I, you know, say in view of the testimony, and what many of us here in our offices, we still have a long way to go in changing the culture of the military and in dealing with victims of MST. But I do appreciate both of your testimony today and the work that is being done to move us in the right direction.

I want to just talk for a minute about the exam threshold. So the exam threshold in the MST claims process, we have been told by the VBA, and this is for Mr. Murphy, that a veteran's statement alone is not sufficient to trigger a compensation and pension exam. However, in the background information you provided my office, and presumably sent out to regional offices, it clearly states that the veteran's lay statement is sufficient to prove the assault occurred. So my question is, how does this work? Is the veteran's tes-

timony enough to prove the assault happened? And how can it not be enough to get an exam?

Mr. MURPHY. Again, I am going to ask Ms. MacDonald to answer that.

Ms. PINGREE OF MAINE. Fine. Fine.

Mr. MURPHY. Again, she is the expert on this area.

Ms. MACDONALD. Thank you, Congresswoman Pingree. It, by itself, in the absence of any other supporting marker would not be enough to request an exam.

Ms. PINGREE OF MAINE. Okay. So thank you for clarifying that. And I think that reinforces why we hear in our helpful conversations with the VBA, or the VA, that you know, we are moving forward on setting a different standard. But on almost a weekly basis, I hear from a veteran who was sexually assaulted while serving in the military. And when they go to the VA with that claim, they are denied because they could not produce a court filing, or a report, or some other kind of proof that the attack occurred. So even though we are often told that the proof is not required, that is not what seems to be happening in your offices. And I do appreciate the increased training, the difficult in changing even the culture of the system. But I guess I have two views and I want to ask your comments on it. I mean, A, I think we have further to go before the implementation of what we are hoping will happen, happens. And while I am not here to promote a piece of legislation, but that is why I submitted the bill that, in a sense, does have reduced evidentiary standards. It would provide a service-connection for MST survivors if they provide a diagnosis of PTSD and a medical link stating that the PTSD is caused by the assault. I believe that is similar to what happens with combat related PTSD claims. And I am of the belief that until we get there, possibly with legislation, possibly with a change in regulation, we are not going to be there. So if you want to talk a little more about that, I just think we see it differently. And I guess my concerns are the testimony we have heard today, the difficulty that people are having getting the assistance that they need.

Mr. MURPHY. I do have a couple of comments. First of all, as you stated, we are a long way from having this down pat and making sure every veteran is taken care of and getting what they are due. Second, that we have made the improvements in the process today that you are seeing because of the consistency of training, the focusing of only a select few individuals that received a much higher level of training than what the general population gets. And specifically focused and targeted around identifying the very subtle markers. This is something that is not public knowledge. It is not generally reported. But some minor, barely noticeable behavior on the part of the veteran is all it takes to say, "Yes, there is something here, plus the veteran's statement, let us move forward with this claim." In fact, I just learned one earlier listening to a previous statement talking about the absence of evidence in a file is also a marker. And I am not saying that, that we are not doing that. I am saying that that was beyond my level of expertise in this area, which is why Ms. MacDonald is sitting next to me today. So again, we have a long way to go. We have made significant progress. But we are not done yet.

Ms. PINGREE OF MAINE. Well again, thank you for the work that you are doing. I think we are all here today because we hear with deep concern the number of people who serve this country and then find themselves victim of military sexual trauma. And we started out with some very stark figures in the beginning here about the difficulty of people being able to get assistance, the difficulty of crimes being prosecuted, the difficulty even for a veteran to come forward. And I think we have to remember over and over that these are very special circumstances. That people who served their country want to continue to serve. We have enormous work to do to change the culture. But I think on the other side we have a lot of work to do to make sure we help those people who need our help. Thank you very much.

Mr. RUNYAN. I thank the gentle lady. The chair now recognizes Ms. Speier.

Ms. SPEIER. Mr. Chairman, thank you for allowing me to sit in on this hearing and to participate in it. I want to thank all the panelists for participating in the hearing today, and for your service. I was, the first bit of good news I heard this morning was from General Hickey at a Committee down at Oversight and Government Reform Committee where we were looking at the delays in VA, the handling of VA cases. And she actually on her own volition went back and looked at the MST cases versus the other PTSD cases and saw that there was a discrimination in the cases as it related to MST/PTSD and that, and you reflected that, I think Mr. Murphy, in your comments. And that now you are sending letters out to those that were declined or denied their claims and asking them to reapply.

Which really makes the case over and over again about what the military has done consistently, which is sweep this issue under the rug. We have done a horrible job. It has gone on now for a quarter of a century. We keep messing around the edges. We create SAPR, we do hearings, we create reports, and then nothing changes. And now we have an absolute scandal at Lackland Air Force Base, where we have 12 trainers implicated, and 31 victims. Only one victim, however, has come forward on her own to file a complaint. Which makes the case over and over again, people, both men and women, are not filing complaints because they know what happens. They find a way to slap them with a disability of personality disorder and then discharge them involuntarily from the military.

So to Congresswoman Pingree's point, if we know that 19,000 occur a year, only 3,000 actually report, of those 3,000 only 200 actually get convictions. There is no motivation for anyone who wants to make a career in the military to report.

So if we know it is 19,000 a year, I think the figures are thrown out as something like 500,000 victims of MST in this country right now. And to think that we are still going to require, knowing that we have done such a lousy job in dealing with these cases and somehow finding the victim at fault, why would we not take the position that we have taken with Agent Orange? Which is basically if you come down with one of these cancers, or one of these conditions, the presumption is that you got it in the military, you got it when you were serving in Vietnam, and there is a presumption made. Why do we not just create a presumption? If someone comes

forward and says they are a victim of military sexual assault or trauma, that we believe them because we have done such a lousy job in terms of handling these cases? Colonel, can you respond to that?

Colonel METZLER. I have some comments on some of the issues that you raised. I think one of the most important that I would like to address is that the department does take this seriously.

Ms. SPEIER. Well you know——

Colonel METZLER. We are absolutely committed to solving this problem.

Ms. SPEIER. I am so tired of hearing persons in your position and higher say there is zero tolerance for MST and yet there is another scandal underway right now, and a court martial taking place at Lackland Air Force Base. We are not doing a good enough job. Until we take it out of the chain of command, these problems will continue to exist because we are not dealing with the conflict of interest that is inherent in that situation. And why would we have unit commanders who have no legal training, have not gone to law school, have no judicial experience, making decisions as to someone's relevance in terms of having an investigation or prosecution move forward?

Colonel METZLER. Ma'am, it is the position of the department that commanders will lead this change. Commanders set the tone in their units. Commanders set standards of discipline. Commanders set the climate of their units. What commanders pay attention to is what gets done and what gets fixed. That is why we are assessing commanders——

Ms. SPEIER. Excuse me, Colonel, but I am about to run out of time, so let me just ask a number of questions and see if you can answer them. How many permanent or temporary transfers have been granted since this new ruling went into effect? How many have been declined? How many special victims units have been created? And have you considered at all the relevance of having an MST/PTSD therapy program that is different from the PTSD program that exists for the general military veterans population? And maybe that is a question to you, Mr. Murphy.

Colonel METZLER. Under the transfer authority that the Secretary ordered, there are transfers that are happening. I do not have the specific data. We have met with all of the services in the last week, talked to them about it. Ma'am, we are happy to get that information and we will provide it to you.

Ms. SPEIER. And actually to the Committee as well. I think that would be——

Colonel METZLER. Absolutely. And that will also be part of our annual report, and it will be part of our official record. So we will make that available to the Committee. With regard to special victims units, that is a process that is underway. The Secretary has asked us to create that in April. We have had meetings with folks to work on the concept. The Army is already working——

Ms. SPEIER. So there is not one?

Colonel METZLER. The special victims unit capability is being created. It was guidance from the Secretary to create that capability. The Army has a very good program that we are modeling that we have met with. I think it is Mr. Strand who has worked on that.

Ms. SPEIER. Russell Strand?

Colonel METZLER. You are familiar with his work. And we are working with the U.S. Army Military Police School because of the special training that they are already providing to some attorneys and to investigators. And it is a concept and a capability that we intend to——

Ms. SPEIER. So the Army has it, but they had it even before the guidance by the Secretary. So when do you anticipate the other services will have these SVUs?

Colonel METZLER. Ma'am, I do not have a specific date. But we will make sure we get that to you.

Ms. SPEIER. And then to you, Mr. Murphy. The question of having a separate kind of therapy program for MST PTSD survivors?

Mr. MURPHY. The separate kind of therapy program falls under the Veterans Health Administration. I do not have any of the VHA folks with me here today. However, I can talk a little bit about that they have dedicated counseling and professionals that we work closely with DoD to ensure that we are getting the handoff of what little evidence does exist. So I cannot answer that for you in detail today.

Ms. SPEIER. Mr. Chairman, can I ask one more question?

Mr. RUNYAN. You may.

Ms. SPEIER. I think the issue that was raised earlier is a relevant one, and you raised it, Mr. Chairman. And I was wondering if it would be helpful to the Committee, and to Members who are concerned about this issue, if the VA would on a quarterly basis provide information to you as Chair of the Committee about how many of these cases are being handled. How many are actually being, claims that are being filed, and how many are actually being granted, and what the percentage of the disability is being granted as a result. To just track to see if the change is permanent and to what extent it is comprehensive.

Mr. RUNYAN. That is very possibly something we can put in Ms. Pingree's piece of legislation.

Ms. SPEIER. Thank you.

Mr. RUNYAN. All right. Well with that——

Colonel METZLER. Mr. Chairman, with your permission there was one other issue that was raised that I did not get a chance to respond to. And it is an important fact that we would like to point out. Since 2006 to 2010, we do have very good data that tells us that the incidents of sexual assault, of all ranges of sexual assault are down. And that the reporting trends are up, the reporting trends have doubled. Now it has been said many times that the trend right now is about 14 percent of victims report. We are not satisfied with that. The data is moving in the right direction. But we are focused on solving this problem. And Congresswoman, we will work this problem, I can assure you.

Mr. RUNYAN. Well I thank you all for your testimony. And ladies, gentle ladies, thank you for coming and being guests here today.

I am not going to make a big closing statement. But I would say this, specifically dealing with this Committee, and I have said it directly to Secretary Shinseki sitting right there at that exact same table. One of the biggest metrics we miss in the VA is customer service. We measure everything else, but was the job we are there

to do, which is service the veteran, done right? And were they satisfied with the result? Because if the VA were a private entity, a company, you would not be in business very long because you would not have very many happy customers. That is the metric we miss every single day. It is three or four or five down the list sometimes. And that is really something that I continue to press and, I hope every other Member of this Committee, and every other Member of this Congress, would agree with that. Because that is truly, what these men and women do for us by putting their lives on the line to sacrifice for our freedoms, the least we can do is give them what, give them by the laws we have created what they are due. Just to that. And most of us would agree we owe them more than that. It is how do we get there?

But with that, on behalf of this Committee I thank all of our distinguished witnesses for their testimony today. I appreciate your service to our Nation's veterans. And you are all now excused. And I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include extraneous material. Hearing no objections, so ordered. I thank the Members for their attendance today and urge that all of you be vigilant participants in the Committee's efforts to ensure that victims of military sexual trauma have access to the benefits they need to live happy and health lives. And this hearing is now adjourned.

[Whereupon, at 4:38 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Jon Runyan, Chairman

Remarks:

Good afternoon. Welcome to our hearing, "Invisible Wounds: Examining the Disability Benefits Compensation Process for Victims of Military Sexual Trauma."

First, I ask unanimous consent to welcome a number of our honorable colleagues who have asked to be allowed to participate as guest Members of the Subcommittee today. Hearing no objection, so ordered.

As a Nation, we call on our armed servicemembers to sacrifice bravely on our behalf. They courageously put their lives at risk and face deadly enemies on the battlefield.

When we think of these enemies, we think of those who oppose our freedom or are American way of life. We certainly do not think of soldiers needing to defend themselves from their fellow servicemembers. However, many of our servicemembers are required to do just that.

Women are the fastest growing population among veterans, making up 8% of the armed forces. However, the Department of Defense estimates that one in four women who join the armed services will be raped or assaulted, but that only about 10% of such incidents are ever reported.

Even more alarming is that of those few who did report incidents of military sexual trauma, over 75% stated that they would not make the same decision about reporting the incident again, due to the consequences it had on their military career.

Despite the fact that many of these incidents go unreported, VA currently estimates that over half a million veterans have experienced military sexual trauma. This includes 17% of veterans from the recent conflicts in Iraq and Afghanistan.

Although this is not the Committee's jurisdiction, there must be zero-tolerance for this behavior in the military, and VA must recognize immediately the trauma inflicted on these men and women.

Accordingly, the focus of today's hearing is how to assist these veterans with obtaining VA benefits for post-traumatic stress disorder, or PTSD. This is often a difficult task given the sensitive nature of these claims and the lack of evidence of documenting such incidents at the time that they occurred.

Although VA has made great progress in adjudicating military sexual trauma claims by providing relaxed evidentiary standards and re-training employees on this issue, SWAN, one of the organizations testifying today, estimates that less than one-third of military sexual trauma PTSD claims are approved by VA, even though 53% of PTSD claims are granted overall.

Although military sexual trauma is not a new issue, it is a serious matter on which more light has been shed in recent years.

As more and more of our brave servicemembers find the inner strength to overcome military cultural challenges, and come forward to seek justice, help and healing, the more the Members of this Committee, DoD, and VA can understand the best means of assisting victims of military sexual trauma with obtaining the VA benefits that they need.

One such veteran will be testifying before us today, and I would like to personally thank Ms. Ruth Moore for coming to Washington and sharing her story with us today.

Victims of military sexual trauma like Ms. Moore carry scars in their hearts for the rest of their lives as a result of what they have endured. Such veterans are indeed deserving of VA benefits to help them enjoy the American way of life that their service has helped to secure.

As the Department of Defense continues to address issues arising from the cultural resistance to reporting such abuse, the VA must continue to work on ensuring that the proper benefits, so needed by these victims, are easily obtainable.

So, I will reiterate - the focus of our hearing today is precisely that—what benefits does VA provide for victims of military sexual trauma, how are these claims adjudicated, and how can this process be improved?

We welcome several witnesses to testify before us today, ranging from representatives of veterans service organizations, to experts on the effects and treatments of military sexual trauma, to officials from VA and the Department of Defense.

I appreciate all of you taking the time to speak with us today about this issue of such importance to so many members of our American community.

Because we have many distinguished guests today, I would like to reiterate my request that our witnesses abide by the decorum and rules of this hearing by summarizing your statements to five minutes or less during oral testimony. Doing so will ensure that the Committee has the opportunity to hear from everyone.

I also remind all present that without any objection, your written testimony will be made part of the hearing record.

I now call on the distinguished Ranking Member for his opening statement.

Prepared Statement of Hon. Jerry McNerney,
Ranking Democratic Member

Good afternoon. I would like to thank everyone for attending today's hearing focused on examining the VA disability compensation process as it pertains to military sexual trauma or MST.

I am happy to join DAMA Subcommittee Chairman Runyan and my colleagues in holding this hearing.

I am also pleased that two of the leading voices in Congress on this issue, Representative Chellie Pingree of Maine, and Representative Jackie Speier of California are accompanying the Subcommittee Members on the dais today. I also welcome and thank Ms. Pingree's constituent, Ruth Moore, accompanied by her husband, for testifying about her MST experience with VA.

Servicemembers who experience military sexual trauma and are brave enough to speak out about their experiences often do so at great risk to their careers and reputation.

The purpose of this hearing today is to evaluate ways in which the Veterans Benefits Administration (VBA) and the Department of Defense (DoD) can better address the needs of veterans affected by MST and identify ways to prevent these horrible assaults, treat and properly compensate the victims.

MST refers to sexual harassment and sexual assault that occurs in military settings. MST often occurs in a setting where the victim lives and works, which means that the victims must continue to live and work closely with their perpetrators.

Many MST victims state that when they do report an incident, their story is dismissed or they are encouraged to keep silent because of the need to preserve organizational cohesion.

This is unfair to the victims. We must put protections in place to ensure a safe haven exists for the women and men who experience military sexual trauma.

Unfortunately, the consequences of MST are a pervasive problem within the Veteran community. According to the Institute of Medicine, prevalence rates of MST range from 20–43%. Many veterans who are victims of MST express frustration with the VA's disability claims process, especially in trying to prove to that the assault ever happened.

For many women and men, when their disability claims for post-traumatic stress related to MST are denied.

However, I am pleased that in July 2010, in response to action taken by this Committee, the VA relaxed its stressor evidentiary standards for post-traumatic stress, which also includes MST.

While this represented a step in the right direction, there are still hurdles that women and men face in receiving the benefits they deserve.

As SWAN points out in its testimony, there are still disparities in compensation and confusion within VBA on when service-connection compensation for MST is warranted.

Training at VA has improved slightly, but VBA claims decisions are still inconsistent and more must be done.

As we build a VA for the 21st century, VA and DoD need to ensure that the proper prevention, counseling, treatment and benefits are available for MST victims.

Veterans should be able to have access to VA personnel who are qualified to advise on the often-sensitive MST related issues. These veterans need to be treated with the dignity and respect that they deserve.

I look forward to hearing from the esteemed panels of witnesses.
Thank you, I now yield back.

Prepared Statement of Hon. Michael R. Turner

Thank you, Chairman Runyan, for holding this important hearing. I would also like to recognize your advocacy on this issue within the House Armed Services Committee. Special thanks, as well, to all the panelists for their advocacy of victim's rights and determination to address the military culture and climate. I have worked with Anu and SWAN for several years now and their contribution to this issue has been instrumental in achieving many legal and policy changes.

Before I start my remarks, I would like to point out that the great majority of the Servicemembers are patriotic citizens that serve their country honorably and selflessly. And while today's hearing may focus on the criminal behavior of a relative few, their behavior should not be used to broadly tarnish the reputation of the many Servicemembers who have honorably sacrificed for their country.

I became involved in this issue in 2008 following the tragic murder of Lance Corporal Maria Lauterbach. Maria reported being sexually assaulted and was later murdered by a fellow Marine while she was stationed at Camp LeJeune, North Carolina. During the course of the investigation a Marine Corps representative told me that "we lost two good Marines today." When, in fact, we had only lost one good Marine, Maria Lauterbach, and another Marine who was a rapist and murder that tarnished the reputation of the Corps. Later, during the course of Congressional hearings on the subject, a Lieutenant General stated that Maria "never alleged any violence or threat of violence in either sexual encounter."

These and several other incidents demonstrated a fundamental lack of understanding of the problem and how to deal with it. In addressing the issue of military sexual assault it is necessary to address some fundamental areas, namely: Command, Culture and Accountability. I think the hearing today strikes at the heart of the cultural element. Culture within the Department of Defense and the Department of Veterans Affairs.

In working on sexual assault issues on the House Armed Services Committee and the Military Sexual Assault Prevention Caucus, which I co-chair with Niki Tsongas, we have sculpted legislation that aims to facilitate a culture that encourages victims to come forward and punishes the criminal actors that degrade our military. The personal nature of sexual assault makes it difficult for victims to come forward and discuss the details of their experience. This is compounded by policies that require victims to repeatedly relive the experience and re-victimize the victims. These additional stresses decrease the likelihood of victims coming forward and permit the retention of criminals. As Anu pointed out in her testimony, the DoD Sexual Assault Prevention and Response Office (SAPRO) report indicated that 86.5% of sexual assaults go unreported. The end result is that some of these criminal later draw DoD and VA benefits, while their victims are left to fight to substantiate their PTSD claims.

Addressing the issue before the Committee today is a step towards creating a more victim-centric system that improves our military by rewarding victims for coming forward and punishing the bad actors. In addressing this issue, Niki Tsongas and I included a provision in the Defense STRONG Act last year requiring the DoD to retain records prepared in connection with sexual assaults involving members of the Armed Forces or dependents of members. That provision was later included in the FY12 NDAA. This provision requires the Department of Defense to permanently retain records of sexual assault in the military, and ensures that a servicemember who is a victim of sexual assault has access to these records. Servicemembers find it difficult to obtain documentation proving their sexual assault once they have left the services because DoD destroys many of these documents after only a few years. It is our hope that improving this process will contribute to removing the negative stigma that surrounds the process and, thereby, improves military culture and climate.

Question:

Col. Metzler and Mr. Murphy. What is the status of implementation of this new policy (HR1540 Sec 586)?

Prepared Statement of Congresswoman Chellie Pingree

Thank you Chairman Runyan and Ranking Member McNerney for allowing me to participate in today's hearing. I also want to thank you for holding this hearing—the topics covered today are extremely important, as the welfare of our veterans' mental health and the disability and mental health system that cares for them should be one of Congress's highest priorities.

Military sexual trauma continues to be a pervasive problem in our Armed Forces. DoD data shows that roughly 19,000 reported assaults occur each year, and that approximately 85% of these assaults go unreported. It happens to both men and women at increasingly high rates.

These attacks on our service men and women are occurring in the active duty ranks and even at the military academies—it is a disgrace that needs to stop now. I commend Defense Secretary Panetta for the changes he is making to DoD policy to prevent MST and prosecute these attackers, but more needs to be done.

Data shows that survivors of MST are very likely to suffer from Post Traumatic Stress Disorder and other mental health conditions, leading many of these veterans to file claims with the VBA. I commend the Veterans Health Administration, which has an "open door" policy, where MST survivors can get free treatment and counseling based on self reported MST.

While the VHA's MST policy does what it can for MST victims, there is another side of the VA that in far too many cases fails MST survivors by producing roadblocks and bureaucratic red tape. Countless MST survivors are so affected by the personal assault they experienced that they file PTSD claims with VBA, only to be denied service connection because they cannot prove the assault occurred.

Since most attacks go unreported, leaving no military documentation for victims to produce during the claims process with VBA. VBA's current policy states that they will be very liberal in deciding MST cases, and should accept "secondary markers" as proof the assault occurred—things like counseling reports for PTSD from MST, letters from family members citing behavioral changes, drug and alcohol abuse, etc . . .

On the surface it appears VBA's policy gives veterans the benefit of the doubt and that VA understands current DOD shortcomings around MST, and common sense prevails when adjudicating these sensitive cases. I would like to commend VBA under Secretary Allison Hickey for her commitment to MST survivors and the increased emphasis she has put on these types of claims while serving as VBA undersecretary.

Unfortunately, however, I am of the opinion that the VA is just too big an agency for anything short of a regulation change to fix this problem. No amount of training can ensure raters take the larger picture into account when reviewing these cases. VBA remains vastly inconsistent when deciding MST cases, and what one Regional Office accepts as a secondary marker, another might deny and still not be violating VBA policy. For instance, I have seen veterans denied service connection for lack of sufficient proof, even after they provided medical reports from in patient counseling for MST-related mental health conditions—at VA Medical Centers.

We have to be sure that VBA gives MST survivors the benefit of the doubt, especially when so many of these survivors have lost faith in the system they swore to uphold. That is why I introduced a bill that would provide service connection for MST survivors if they provide a diagnosis of PTSD and a medical nexus stating the PTSD is caused by the assault.

This language in this bill is very similar to the July 2010 change VBA implemented for veterans suffering from PTSD related to fear of hostile enemy action or terrorist activity. These veterans need only show a diagnosis of PTSD, a medical link and the claimed stressor must be consistent with the types of events consistent with military service. Unfortunately, the data continues to show that sexual assault in the military is so pervasive that it is consistent with the types of events consistent with military service. I want to thank Chairman Runyan for his support of the bill, as I know it would go along way to addressing the issues we continue to hear about from veterans and their families.

Let's be clear. The bad guys in these stories are the perpetrators. They are the villains and the ones who should be held accountable. But by creating a policy that denies justice to the victims and forces them to spend years or even decades fighting for the benefits they deserve, we are deepening the wounds for these veterans and making it all that much harder for them to get on with their lives.

Prepared Statement of Anu Bhagwati

Dear Mr. Chairman and Members of the Committee:

Thank you for holding this hearing on a critical issue facing our veterans' community, and thank you for the opportunity to present the views of the Service Women's Action Network (SWAN) on the challenges confronting veterans who file claims for PTSD suffered as a result of sexual assault and sexual harassment in the military.

SWAN has been advocating for changes to the VA claims process for several years. We actively supported the VA's change to the claims process for combat related PTSD-claims and have provided testimony many times to both House and Senate committees on issues and challenges facing women veterans at both the VHA and VBA, and the unique challenges faced by veterans filing Military Sexual Trauma (MST) claims.

According to VA, PTSD is the most common mental health condition associated with MST. For women veterans, MST is a greater predictor of PTSD than combat.[1] Studies also indicate that sexual harassment causes the same rates of PTSD in women as combat does in men.[2] And 40 to 53% of homeless women veterans have been sexually assaulted in the military.[3] Simply put, MST has devastated the veterans' community.

The MST claims process is broken at best. VA's PTSD policy discriminates against veterans who were sexually assaulted or harassed while in uniform by holding them to a standard which is not only higher than that of other groups of veterans suffering from PTSD, but also completely unrealistic for the majority of survivors to meet. As we discovered by analyzing VA claims data (see below), the process fails the majority of survivors. The process also serves to betray and re-traumatize these veterans, often directly contributing to worsening symptoms and increasing rates of suicide.

First, it should be noted that the MST PTSD claims process adversely affects all veterans, not just women. Many men suffer from the effects of sexual violence experienced while serving in the military. According to the Department of Defense, 12% of all unrestricted sexual assault reports are made by men.[4] Additionally, according to VA, 45.7% of the veterans who screened positive for MST in 2010 were men, and 39% of veterans receiving treatment for MST were men.[5]

Veterans who suffer from the debilitating effects of Military Sexual Trauma face unique challenges in obtaining disability compensation from the VA. In 2011, SWAN and the American Civil Liberties Union (ACLU) filed a Freedom of Information Request with the VA for data on MST claims. The data obtained through litigation showed that during FY 2008, 2009 and 2010, only 32.3% of MST-based PTSD claims were approved by VBA compared to an approval rate of 54.2% of all other PTSD claims during that time.[6] As a point of comparison, data obtained by Veterans for Common Sense indicates that 53% of Iraq and Afghanistan deployment related PTSD claims through October 2011 were approved.[7]

Looking more deeply at the MST data, SWAN discovered that among veterans who had their MST–PTSD claims approved by VA, women were more likely to receive a 10% to 30% disability rating, whereas men were more likely to receive a 70% to 100% disability rating.[8]

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[1] Maureen Murdoch, et al., "Gender Differences in Service Connection for PTSD," *Medical Care* 41, no. 8 (2003), 950–961.

[2] Maureen Murdoch, et al., "The Association between In-Service Sexual Harassment and Posttraumatic Stress Disorder among Compensation-Seeking Veterans," *Military Medicine* 171, no. 2 (2006), 166–173.

[3] Erik Eckholm, "Surge Seen in Number of Homeless Veterans," The New York Times, November 8, 2007; b. Donna L. Washington, et al., "Risk Factors for Homelessness among Women Veterans," *Journal of Health Care for the Poor and Underserved* 21 (2010): 81–91.

[4] Department of Defense, SAPRO. 2012. "Fiscal Year 2011 Annual Report on Sexual Assault in the Military".

[5] Department of Veterans Affairs, Office of Mental Health Services. 2011. "Summary of Military Sexual Trauma-related Outpatient Care Report, FY 2010." Washington, D.C.: Department of Veterans Affairs, Office of Mental Health Services.

[6] In conjunction with the ACLU, SWAN filed a Freedom of Information Act (FOIA) request to obtain data concerning approval/rejection rates of MST-based PTSD disability claims. Based on data analyzed for fiscal years 2008–2010, 32.3% of MST- based PTSD claims were approved vs. 54.2% of all other PTSD claims over the same period. !

[7] Veterans for Common Sense. 2012. "Iraq and Afghanistan Impact Report". Washington D.C.: Available at *http://veteransforcommonsense.org/wp-content/uploads/2012/01/VCS—IAIR—JAN—2012.pdf*.

[8] In conjunction with the ACLU, SWAN filed a Freedom of Information Act (FOIA) request to obtain data concerning gender differences in compensation awarded for MST-related PTSD

We drew several important conclusions from these findings. First, under current VA policy, veterans who file a PSTD claim based on their Military Sexual Trauma have only a 1 in 3 chance of getting their claim approved. Also, among women veterans with MST-related PTSD, data suggests a strong gender bias in disability ratings in favor of men.

When we look at VA's PTSD claims policies on paper, we shouldn't be surprised that so few MST PTSD claims get approved: the evidentiary standard for claims based on rape, sexual assault or sexual harassment is higher, and completely unrealistic.

The language in the regulation that establishes the required evidence for what the VA calls a "in-service personal assault" (38 CFR 3.304, Chapter 1, Part 3, Subpart A) differs radically from the language used to describe the evidence required for combat, deployment, prisoners of war, and all other PTSD claims. In fact, Paragraph (f) allows for lay testimony as acceptable evidence in all other PTSD cases except in cases of an in-service personal assault.

Instead the regulation lists a litany of other hypothetical evidence which can be submitted by a veteran ranging from police reports, statements by family members, pregnancy and tests for sexually transmitted diseases. The regulation also allows for negative changes in behavior to be taken into consideration. It is worth noting that the regulation does require VA claims officers to accept such evidence, it only allows for the veteran to submit it. [9]

If 2 out of 3 MST claimants still cannot meet this PTSD evidentiary burden, the policy can hardly be called generous. VA policy fails veterans for a variety of reasons. First, sexual assault and sexual harassment in the military are notoriously under-reported. According to the Pentagon's Sexual Assault Prevention and Response Office (SAPRO), 86.5% of sexual assaults go unreported, [10] meaning that official documentation of an assault rarely exists. Secondly, prior to the new evidence retention laws passed in the 2011 National Defense Authorization Act, the services routinely destroyed all evidence and investigation records in sexual assault cases after 2 to 5 years, leaving gaping holes in MST claims filed prior to 2012. Lastly, the evidentiary standard described in the regulation does not take into consideration the reality that many victims do not report the incident(s) to anyone, including family members, for a variety of legitimate reasons, including shame, stigma, embarrassment, or disorientation associated with sexual trauma. Although sexual assault increases the chance of adverse emotional responses and behaviors, [11] it does not mean that all MST claimants will experience these symptoms. In fact, SWAN has spoken to many assault survivors who demonstrate changes in behavior that are not included in the regulation, such as improved job performance as a means of coping with the trauma.

In the MST community, the failures of the VA claims process are notorious. SWAN has spoken with veterans who suffer PTSD related to both MST and combat—what veterans cynically call the "double whammy". These veterans chose to abandon their MST claims and submit a claim only for combat related PTSD, as they felt their combat claim was more likely to be approved, and that the uphill battle to file an MST claim wasn't worth the agony.

SWAN has presented our data to VA Secretary General Eric Shinseki and to General Allison Hickey, the Under Secretary for Benefits at VBA, to demand change to VA policy on MST claims. After a series of conversations SWAN had with VBA about its discriminatory practices, the Under Secretary issued a memo in June 2011 providing further guidance to claims officers and instituting training requirements for processing MST claims. However, examination of both the letter and the training revealed it simply reinforced the existing regulation which our data shows is not working. Rather than resolve the problem by easing the double standard placed on MST claimants, the VBA has done nothing but reinforce failure.

To fix MST claims policy, VBA must immediately revise the regulation (38 CFR 3.304, Chapter 1, Part 3, Subpart A) to provide language that establishes the same evidentiary requirements for MST-based PTSD claims that it does for other claims. Specifically, if the evidence establishes a diagnosis of PTSD during service and the veterans' mental health provider connects that claimed stressor to the patient's

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claims. The data showed men are more likely than women to receive 70% to 100% ratings for MST-related PTSD claims, and women were more likely to receive 10% to 30% ratings (p<.001).

[9] 38 C.F.R. § 3.304: Pensions, Bonuses, and Veterans' Relief. (2012).: Available at: *http://ecfr.gpoaccess.gov/cgi/t/text/text- idx?c=ecfr&tpl=/ecfrbrowse/Title38/38tab—02.tpl*

[10] Department of Defense. SAPRO, 2012.

[11] Dean G. Kilpatrick, Ph.D. 2000. "The Mental Health Impact of Rape". National Violence Against Women Prevention Research Center, Medical University of South Carolina. Available at: *http://www.musc.edu/vawprevention/research/mentalimpact.shtml.*

service, then in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay testimony alone should sufficiently establish the occurrence of the claimed in-service stressor.

Furthermore, there should be absolutely no requirement that veterans filing MST claims go through an independent Compensation and Pension exam to verify that they have PTSD. We know from talking to countless veterans that these exams often unfairly reverse the diagnosis that was made by qualified VA MST counselors or other mental health providers. C & P exams are terrifying for veterans who have been assaulted or harassed as it forces them to talk about traumatic and devastating experiences with complete strangers. These experiences often taken years or even decades for veterans to come to grips with, or to talk comfortably about, and veterans should not be forced to repeat them to complete strangers who often lack the sensitivity or professional qualifications to speak to survivors of sexual trauma. The trust that is built between a MST counselor or mental health provider and his/her patient is one that cannot be replaced by strangers. VBA must trust the expertise of VHA or other sexual trauma experts who have worked intimately with their patients.

Additionally, to sensitize claim reviewers to the needs of assault and harassment victims, the VA should implement the recommendations of the Institute of Medicine Committee on Veterans' Compensation to collect gender-specific data on MST claim decisions, develop additional MST-related reference materials for raters, and incorporate training and testing on MST claims into its rater certification program.[12] The agency should also establish a presumption of soundness for the diagnoses of its own treating physicians and counselors; claim reviewers should not have the authority to second-guess evaluations by agency medical professionals or to discount VA treatment records in favor of one-time Compensation and Pension (C&P) exam results.

Finally, SWAN proposes revising the current VA work credit system, which paradoxically prolongs the adjudication process by privileging speed over accuracy in initial claim determinations. By measuring employee productivity strictly by number of cases processed, the VA offers reviewers an incentive to take any shortcut necessary to clear their desks of pending claims. The resulting combination of too much work and too little time ultimately gives rise to premature—and inaccurate—determinations, setting in motion years of appeals. In order to encourage accurate determinations at the Regional Office level and remove the incentive to recycle claims, the agency should award work credit only after the final stage of review.

Thank you very much for your attention. I would be happy to answer any questions.

Executive Summary

The Service Women's Action Network (SWAN) has worked on the issue of Military Sexual Trauma (MST)- related Post Traumatic Stress Disorder (PTSD) claims for a number of years now with the VA, VBA and Congress. SWAN has advocated for a relaxation in the evidentiary standards for MST-based PTSD claims to allow lay testimony of the veteran to be used to reflect the standards of evidence used in other PTSD claims. In 2011, SWAN and the ACLU filed Freedom of Information Act requests with the VA to ascertain the scope of MST-based PTSD claims, and to specifically examine approval rates and disability ratings of those claims.

Examination of the documents produced by the VA clearly shows that the current system in use by the VBA that employs a higher standard of evidence for sexual assault claims results in only 1 in 3 (32.3%) MST- based PSTD claims being approved. This is much lower than the 1 in 2 (54.2%) acceptance rate of all other PTSD claims. Additionally, an examination of disability ratings revealed a strong bias, as women were more likely to receive a 10 to 30 percent rating and men were more likely to receive a 70 to 100 percent disability rating.

This data reinforces what SWAN and many other veterans' advocates already know: the possibility of getting an MST-based PTSD claim approved by the VBA under the current regulations continues to be an arduous and overwhelmingly difficult process for the veteran, and is a process that more often than not results in a ruling unfavorable to the veteran.

To improve MST claims policy, VBA must immediately revise the regulation (*38 CFR 3.304, Chapter 1, Part 3, Subpart A*) to provide language that establishes the same evidentiary requirements for MST-based PTSD claims that it does for other

[12] Committee on Veterans' Compensation for Posttraumatic Stress Disorder, Institute of Medicine and National Research Council of the National Academies, *PTSD Compensation and Military Service* (Washington DC: The National Academies Press, 2007).

claims. Specifically, if the evidence establishes a diagnosis of PTSD during service and the veterans' mental health provider connects that claimed stressor to the patient's service, then in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay testimony alone should sufficiently establish the occurrence of the claimed in-service stressor.

Furthermore, there should be absolutely no requirement that veterans filing MST claims go through an independent Compensation and Pension (C &P) exam to verify that they have PTSD. We know from talking to countless veterans that these exams serve no purpose and in fact often unfairly reverse the diagnosis that was made by qualified VA MST counselors or other mental health providers. C & P exams are terrifying for veterans who have been assaulted or harassed as it forces them to talk about traumatic and devastating experiences with complete strangers. These experiences often take years or even decades for veterans to come to grips with, or to talk comfortably about, and veterans should not be forced to repeat them to complete strangers who often lack the sensitivity or professional qualifications to speak to survivors of sexual trauma. The trust that is built between a MST counselor or mental health provider and his/her patient is one that cannot be replaced by strangers. VBA must trust the expertise of VHA mental health experts who have worked intimately with their patients.

Additionally, to sensitize claim reviewers to the needs of assault and harassment victims, the VA should implement the recommendations of the Institute of Medicine Committee on Veterans' Compensation to collect gender-specific data on MST claim decisions, develop additional MST-related reference materials for raters, and incorporate training and testing on MST claims into its rater certification program. The agency should also establish a presumption of soundness for the diagnoses of its own treating physicians and counselors; claim reviewers should not have the authority to second-guess evaluations by agency medical professionals or to discount VA treatment records in favor of one-time C&P exam results.

Finally, SWAN proposes revising the current VA work credit system, which paradoxically prolongs the adjudication process by privileging speed over accuracy in initial claim determinations. By measuring employee productivity strictly by number of cases processed, the VA offers reviewers an incentive to take any shortcut necessary to clear their desks of pending claims. The resulting combination of too much work and too little time ultimately gives rise to premature—and inaccurate—determinations, setting in motion years of appeals. In order to encourage accurate determinations at the Regional Office level and remove the incentive to recycle claims, the agency should award work credit only after the final stage of review.

Prepared Statement of Joy J. Ilem

Messrs. Chairman and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this oversight hearing focused on the process and procedure involved in veterans' obtaining disability compensation benefits for post-traumatic stress disorder (PTSD) associated with military sexual trauma (MST), specifically on the types of evidence that may be submitted to substantiate a claim related to MST, and an exploration of ideas that may improve the evaluations of these claims.

For a number of years, DAV has advocated greater collaboration between offices of the Department of Veterans Affairs (VA) and the Department of Defense (DoD) to address conditions related to MST and to identify better ways to treat and properly compensate veterans for those conditions. We also continue to express a fervent hope that DoD is effectively addressing methods to prevent the incidence of sexual assaults and harassment within all branches of the military services.

This topic is obviously extremely sensitive to many service members, veterans and the respective Departments that are responsible for the safety and well-being of service members and veterans. When a service member is wounded by enemy rifle fire or mortar shrapnel in engagement with an enemy, as a society we recognize the sacrifice and loss of our wounded military personnel, but when a military service member is wounded by personal or sexual violence, often perpetrated by a fellow service member, military authorities and society in general respond in a very different way.

The continued prevalence of sexual assault in the military is alarming and has been the object of numerous military reports, Congressional hearings, documentaries and media coverage. Unfortunately, recent media reports do not lend confidence that DoD is succeeding in its goal of reducing and eliminating this scourge;

however, it appears from recent developments that the Secretary of Defense has determined to address MST in a new and enlightened manner compared to the past. He announced the establishment of independent special victims units to investigate incidents of MST in the military ranks. He also indicated DoD will address some of its historic problems in archiving records associated with the incidence of MST.

In 2005, the DoD established the Sexual Assault Prevention and Response Office (SAPRO). This organization is responsible for all DoD sexual assault policy and provides oversight to ensure that each of the military service's programs complies with DoD policy. SAPRO serves as the single point of accountability and oversight for sexual assault policy, provides guidance to the DoD components, and facilitates the resolution of issues common to all military services and joint commands. The objectives of DoD's SAPRO policy are to specifically enhance and improve prevention through training and education programs, ensure treatment and support of victims, and enhance system accountability.

According to SAPRO, in 2011 reports of sexual assault were filed by 3,192 service members across all military service branches, a 1% increase over 2010 and a 1.1% decrease from 2009.[1] However, DoD recognizes that these types of crimes are remarkably under-reported. For last year, DoD projected a more accurate number, likely closer to 19,000 assaults, based on its bi-annual *Workplace and Gender Relations Survey of Active Duty Members (WGRA).*

VA data bears out the significant reports of MST. According to VA, during fiscal year 2009, 21.9 percent of women and 1.1 percent of men screened by the Veterans Health Administration (VHA) reported that they had experienced an in service stressful MST event. Another VA study found that of 125,000 enrolled veterans screened, about 15 percent of women veterans from Operations Iraqi and Enduring Freedom reported experiencing sexual assaults or harassment during military service.[2] VA research also indicates that men and women who report sexual assault or harassment during military service were more likely to be diagnosed with a mental health condition. Women with MST had a 59 percent higher risk for mental health problems; the risk among men was slightly lower, at 40 percent.[3] The most common conditions linked to MST were depression, PTSD, anxiety, adjustment disorder, and substance-use disorder.

The complaints we hear from veterans regarding MST are primarily focused on the VBA disability claims process. Many survivors indicate that they are frustrated with the process particularly in cases when the sexual assault was not officially reported. They express a feeling of being "re-traumatized" in their efforts to get help from VBA even when they have provided significant evidence; statements from witnesses, friends or family; a detailed account of the incident; along with a diagnosis and extensive treatment records from a VA or non-VA mental health provider—only to have the claim for service-connection denied.

Unfortunately, many service members who experience these types of traumas do not disclose them to anyone until many years after the fact but frequently experience lingering physical, emotional or psychological symptoms following these incidents. When a service member experiences sexual assault during military service there are a number of complicating factors that often prevent or discourage survivors from coming forward and reporting the incident to their superiors. Fear of retribution within the military unit structure; the perpetrator is their superior or a friend of the superior to whom they must report; and negative impact on military career are just a few reported barriers to coming forward and reporting such incidents. Traditional military culture and the military's closed system for reporting, investigating and prosecuting these types of crimes also constitute barriers against reporting such incidents. Despite DoD's "zero-tolerance" policy, reports continue to document these incidents. Not only is there stigma, shame, guilt, and feelings of isolation associated with sexual assault in general, to add insult to injury, in some cases, these incidents are not being properly addressed as mandated by policy through the chain of command. Perpetrators often are not punished.

On their discharge from military service many survivors of MST end up seeking health care and mental health counseling services for MST from the VA health care system. Under a current Veterans Health Administration (VHA) policy, all patients are screened for MST and receive medically necessary treatment and counseling

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[1] Department of Defense Sexual Assault Prevention and Response, Annual Report on Sexual Assault in the Military, Fiscal Year 2011; April 2012. *http://www.sapr.mil/media/pdf/reports/Department—of—Defense—Fiscal—Year—2011—Annual—Report—on—Sexual—Assault—in—the—Military.pdf.*

[2] US Dept of Veterans Affairs, VA Research Currents. November-December 2008. *http://www.research.va.gov/resources/pubs/docs/va—research—currents—nov-dec—08.pdf.*

[3] *Ibid.*

without charge for MST-related conditions at VA health care facilities and in VA Vet Centers. Service connection or disability compensation is not required for eligibility to gain access to this treatment.

Establishing a veteran's service connection for PTSD requires: (1) medical evidence diagnosing PTSD; (2) credible supporting evidence that the claimed in-service stressor actually occurred; and (3) medical evidence of a link between current symptoms and the claimed in-service stressor.

According to current VBA policy, if a PTSD claim is based on in-service personal assault, evidence from sources other than a veteran's service records may corroborate a veteran's account of the stressor incident. Examples of such evidence include, but are not limited to: records from law enforcement authorities, rape crisis or mental health counseling centers, hospitals, or physicians; pregnancy tests or tests for sexually transmitted diseases; and statements from family members, roommates, fellow service members, or clergy. Additionally, evidence of behavioral changes following the claimed assault is one type of relevant evidence that may be found in these sources. Examples of behavioral changes that may constitute credible evidence of the stressor include, but are not limited to: a request for a transfer to another military duty assignment; deterioration in work performance; substance abuse; episodes of depression, panic attacks, or anxiety without an identifiable cause; or unexplained economic or social behavioral changes (title 38 C.F.R. § 3.304(f)(5).)

Also noteworthy, VBA's policy prohibits the denial of claims for service connection for PTSD based on in-service personal assault without a rater's first advising the veteran claimant that information from sources other than the veterans' service records or evidence of behavior changes may constitute credible evidence of the stressor and allowing the veteran an opportunity to furnish this type of evidence or advise VA of potential sources of such evidence. Finally, the regulation provides that VA may submit any evidence it receives to an appropriate medical or mental health professional for an opinion as to whether it indicates that a personal assault occurred.

Unfortunately, even with the liberalization of the regulations, if an assault is not officially reported during military service, establishing service connection later for conditions related to MST can be very challenging. According to an Institute of Medicine (IOM) National Research Council report on PTSD compensation in 2007, significant barriers prevent women from being able to independently substantiate their experiences of MST, especially in combat arenas.[4] The IOM report concluded that little research exists on the subject of PTSD compensation and women veterans and noted that available information suggests that women veterans are less likely to receive service connection for PTSD and that this gap is related to their being unable to substantiate non-combat traumatic stressors such as MST. The committee stated that VA guidance for rating these cases at that time addressed MST specifically, but that little attention was being paid to the unique challenges of documenting an in-service stressor or approaches for solving this problem. DAV is pleased to report that the Veterans Benefits Administration has made numerous improvements in adjudication policies on MST since that report was filed.

In May 2010, VBA officials testified that all rating specialists in VA regional offices were provided with detailed information on proper claims processing methods in a 2005 training letter, in an effort to ensure that veterans who filed claims associated with MST received fair and thorough consideration of those claims.[5] Following the joint hearing on May 20, 2010, VBA responded to DAV's request to include SAPRO information in its M–21–1MR, Part IV, Subpart ii, Chapter 1, Section D for these types of claims. In December 2011, VBA amended its guidance to VA rating specialists, expanding requirements for raters examining personal trauma cases based on MST, including using SAPRO as a source for possible documentation.

We appreciate these specific changes made by VBA, including the information about SAPRO, but DAV remains concerned about how many claims may have been denied prior to that information being included in the manual or on faulty application of the existing regulations.

In preparing for this hearing we contacted VBA officials, through our National Service Officer (NSO) Corps, to see what references are currently being used by rat-

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[4] Institute of Medicine and National Research Council of the National Academies, Committee on Veterans' Compensation for PTSD, Board on Military and Veterans Health, Board on Behavioral, Cognitive, and Sensory Sciences; *PTSD Compensation and Military Service.* Washington DC, 2007.

[5] Bradley G. Mayes & Susan McCutcheon, RN, EdD; Joint Statement before the House Veterans Affairs Committee, Subcommittee on Disability Assistance and Memorial Affairs, "Healing the Wounds: Evaluating Military Sexual Trauma Issues," May 20, 2010. *http://democrats.veterans.house.gov/hearings/Testimony.aspx?TID=72876&Newsid=577&Name=%20Bradley%20G.%20Mayes.*

ing specialists/adjudicators in developing PTSD claims based on MST. A document associated with a December 2011 "Fast Letter" provides very detailed and comprehensive guidance regarding these claims to include: pertinent regulations; statutory definition of MST; related court decisions; specific "markers" to examine in veterans' records; timing for ordering a PTSD examination; and proper development actions to be taken prior to a decision being rendered in the case.

Most notably in the document we found a number of clear examples and statements to raters emphasizing the fact that a special obligation exists on VA's part to assist claimants in gathering, from sources other than in-service records, evidence corroborating an in-service stressor and to help fully develop their claims particularly in MST cases given the unique problems of documenting personal-assault claims. The instructions are concise—that evidentiary development must proceed under the special requirements of title 38, C.F.R., § 3.304(f)(5) and that a veteran's complete military record should be obtained if necessary, and reasonable efforts expended to obtain any other evidence a veteran may identify as a potential source to support the claim. The document goes on to explain the purpose of the liberalizing categories in the regulation is to recognize the difficulties inherent in establishing service-connection for PTSD claims based on MST and other personal assaults and to provide the basis for a relaxed evidentiary standard and a liberal approach to evaluation of these claims.

The most salient feature made in the Fast Letter's attachment is to emphasize that current regulations and court cases do not require actual documentation of the claimed stressor, and that the opinion of a qualified mental health clinician is considered credible supporting evidence of the claimed MST stressor. Nevertheless, the letter notes that the final decision on service connection remains with VBA raters.

To DAV, the question at hand for this Subcommittee is whether VBA adjudicators and rating specialists who are responsible for developing and rating MST claims are using all the amended provisions in M21–1 and following those prescribed VBA-wide guidelines in the Code of Federal Regulations to assist veterans in uncovering potential evidence that may be available to support their claims, even if unreported. In cases where veterans indicated that no official report of assaults were filed, VA adjudicators should be asking veterans detailed questions or considering stressor statements provided by veterans to determine if other reports could have documented these events (such as calls or visits to rape crisis centers or mental health counseling centers; requests for pregnancy tests or tests for sexually transmitted diseases; statements in personal diaries or letters to clergy or family members immediately following personal assaults).

In our view, if a veteran indicates an assault took place on a specific date(s), he or she should be asked about subsequent treatment for any health or mental health problems following the sexual assault, i.e., complaints of stomach pain; nausea; vomiting; headaches; anxiety; panic attacks; depression; or suicidal ideation, etc. Rating specialists should be examining military personnel records for requests for transfer filed by individuals following assault to another duty assignment; a deterioration in work performance noted; or documentation of a sudden onset of substance abuse or other unexplained social or behavioral changes. The M21–1 guidance lists additional options to assist VBA claims developers but it unclear whether these efforts are consistently and exhaustively being made. DAV asks this Subcommittee to require VBA to examine compliance with this guidance system-wide and submit a report of its findings to aid the Subcommittee in its oversight role.

We bring one more issue to the Subcommittee's attention on this topic. Under DoD's confidentiality policy, military victims of sexual assault have two reporting options, "restricted" reporting and "unrestricted" reporting. Restricted reporting allows a sexual assault victim to confidentially disclose the details of the assault to specified individuals and receive medical treatment and counseling, without triggering any official criminal or civil investigative process. Despite the progress on the VA's part to include SAPRO information in its M21–1 manual, to maintain confidentiality in the case of restricted reporting, DoD policy prevents release of MST-related records with limited exceptions. However, VA is not specifically identified as an "exception" for release of records in DoD's policy and it is unclear if VA could gain access to these records even with permission of the veteran. One of DAV's primary concerns is that VA be able to access restricted DoD records (with the veterans' permission) documenting reports of MST for an indeterminate period. To establish service connection for PTSD there must be credible evidence to support a veteran's assertion that the stressful event actually occurred. Restricted records are highly credible resources but it is questionable if they are readily available, even with the consent of the veteran. With the veteran's authorization, we believe DoD should provide VA adjudicators access to all MST records, whether restricted or unrestricted, to aid VBA in adjudicating these cases.

We also have questions with respect to where and how physical assessment records that are completed following assaults and subsequent mental health treatment records related to the restricted MST reports are kept and for how long. We are concerned that these records are being maintained separately from victimized service members' medical treatment and personnel records and whether each service maintains MST records in a consistent manner. According to DoD policy physical evidence associated with a restricted report of an MST event is destroyed after one year if the service member or veteran does not wish to pursue civil or criminal sanctions against the perpetrator. Legislation is pending in the Senate that would extend this period of records retention for restricted MST records to five years. DAV supports an extension of this period to 50 years, matching the current DoD policy on retention of unrestricted records of sexual assaults.

DAV NSOs continue to assist MST victims with their claims for disability compensation. In this work, however, our NSOs are frustrated at the routine occurrence that MST claims are denied by VA for lack of evidentiary documentation. This suggests that, in some cases, VBA rating specialists are not following current policy as detailed in this statement. For these reasons and more, it seems to DAV that the agencies that are responsible for monitoring and reporting on MST, and providing benefits and services to survivors of MST, as well as preventing the problem at its source, should work in concert to lower the burden of this claims process and ensure service members and veterans are fully assisted by the government and their advocates in securing the benefits they deserve and have earned. In recent days we are advised that more collaboration is now occurring between leaders of VBA and SAPRO, but we await the results of these efforts, especially in relation to records keeping, archiving and accessing MST documentation.

Additionally, we urge VBA to identify and map claims related to personal trauma with a focus on MST to determine the number of claims submitted annually, their award rates, denial rates, and the conditions most frequently associated with these claims. We believe this type of reporting would be helpful to the Subcommittee in its oversight role. Therefore, DAV renews our request that VBA develop this important data-set and make it public. Finally, VBA is responsible for ensuring that its claims staffs are properly trained and compliant with the procedures and policies outlined in this testimony to assist veterans in producing fully developed claims; therefore, VBA should conduct its own oversight to review these claims to ensure the directives that have been issued are in fact being followed.

Mr. Chairman, again DAV thanks you for the opportunity to share our views at this important hearing focused on MST related disability claims. We strongly believe that survivors of sexual assault during military service deserve recognition, assistance in developing their claims and compensation for any residual conditions found related to the assault. DAV believes these cases need and deserve special attention. Because of the circumstances of these injuries, victimized individuals who have come forward are courageous, and their courage needs to be recognized by the government.

In the past decade, progress has been made on this issue; however, more needs to be done to ensure that these disabled veterans are properly compensated for conditions related to MST on an equitable basis in comparison to veterans disabled by other causes. We continue to hope hearings of this nature can not only help heal these deep wounds that are often invisible but have profoundly changed the lives of those affected, but also stimulate both Departments to improve their efforts to address them and the underlying causative factors.

Establishing service connection for a condition related to MST is important on a number of levels. Specifically, veterans with service connection gain improved access to VA health care. Disability compensation can also make a significant difference in a disabled veteran's financial stability and overall health and well-being. Finally, and most importantly for many MST survivors, being rated service connected for mental and physical disabilities attributed to MST represents validation, connotes gratitude for their service to their country and recognizes the tribulations they endured while serving.

We appreciate the attention to these issues and hope the Subcommittee will consider the issues of concern and recommendations DAV has made today. I would be pleased to address your questions, or those of other Subcommittee members.

Prepared Statement of Lori Perkio

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to provide testimony on behalf of The American Legion regarding the obstacles faced by veterans applying for compensation benefits related to military sexual trauma. Disability compensation is, in its most basic sense, based on the residual effects of injury or disease incurred in service. There are many potential residual effects resulting from sexual trauma incurred in the military, ranging from disorders of the genitourinary system to sexually transmitted diseases to Posttraumatic Stress Disorder (PTSD). As with any service connected disability, in order to establish service connection, a veteran must prove three points of fact in conjunction with the disorder. A veteran must prove there is a current condition. A veteran must establish evidence showing the occurrence of the event or disease during their period of service. Finally a medical opinion from a doctor is required, providing a nexus between the event in service and the present condition.

For victims of Military Sexual Trauma (MST) the most difficult point to prove is usually the occurrence of the event in service. There are a variety of reasons for this difficulty. Some of these reasons are institutional or even societal. Some of these reasons revolve around the circumstances and culture often associated with the triggering incidences.

The VA is clearly aware of the difficulties the victims of MST face in conjunction with the claims process. In 2004 a document produced by the Veterans Health Initiative (VHI) on MST recognized some of the challenges and offered advice to VA health care providers regarding patients of theirs who might be seeking service connection and compensation for residual effects of MST incurred in service.

The guide recognizes some of the "downsides" veterans might face filing a claim. Veterans will be forced to undergo detailed descriptions of the horrifying events which have resulted in their present PTSD symptoms. Many veterans attach symbolic value to receiving service connection and could be further traumatized by repeated rejections and denials. Citing a 1995 Armed Forces Sexual Harassment Survey which stated "59 percent of women filing rape charges while they were in service said they were not taken seriously." The guide worries that "For sexually traumatized veterans whose attempts for redress in the military were disbelieved, minimized or even punished, denial of service-connection [sic] may represent a re-enactment of earlier 'betrayals'"

Further complicating the process is that in many cases there may be no records which could verify a veteran's claim of assault or sexual trauma in service. As mentioned above, some long standing patterns which are now changing slowly in the military created a negative environment for victims to file charges of rape or assault in the service. When such a culture existed, many chose not to even file due to the arduous task ahead where the victim was as much on trial as the attacker, if not more so.

Even new military programs developed to help victims deal with sexual trauma in the military are often based on anonymity, to assuage concerns of victims who feel their reporting of the incident may adversely impact their career. While this may actually be increasing the number of victims who receive needed help, and is important, it can be disastrous in a long term sense for veterans who file claims for disability related to these assaults, as there are no records to link specifically to them in service.

The lack of available data is noted in 38 CFR § 3.304(f)(5) which clearly recognizes the frequent absence of concrete information in the military record to indicate the occurrence of such traumatic events and notes in the adjudication of posttraumatic stress disorder claims that alternate sources of information can be used to indicate the presence of such an event. Recognizing the importance of types of evidence such as behavior changes, deterioration in work performance, substance abuse, episodes of depression, unexplained economic or social behavior changes and the like, the regulations show the difficulty inherent in proving the existence of the event in question. Paradoxically, often these events must be theorized as existing in the holes left by gaps in what records are actually present.

Despite the regulatory requirement to pay special attention to these types of information, American Legion service officers frequently report that this is not how these claims are actually adjudicated in the field. Oftentimes, the special attention required is only evident once the claim reaches the Board of Veterans Appeals after many years of an arduous appeals process. Some veterans do not even see the proper deference towards these types of evidence until their claim appears before the

Court of Appeals for Veterans Claims. Simply put, despite regulations which require VA to pay "special attention" to alternate sources of information, all too often veterans are told the additional information is not compelling enough to make a difference. All too often it seems, there is no special attention granted to this information.

In a statement released on July 11th of this year, VA delineated an express lane process for veterans' claims including "Special Operations" treatment for PTSD claims associated with MST. Presumably, under this "Special Operations" treatment these MST PTSD claims will finally receive the proper deference due alternative forms of evidence, although it is entirely too early to see what impact, if any, the special treatment will have on MST PTSD claims.

Interestingly, the VA has recently tackled the difficult issue of adjudicating claims for PTSD in cases where there was a known lack of records to corroborate a veteran's claim. In 2010, in recognition of the frequent absence of concrete records to documented occurrences in combat zones, VA changed their regulations relating to the adjudication of PTSD claims related to combat type stressors that occurred in combat zones. The decision to change these procedures came about after careful consideration, and involved a procedure which mandated a VA doctor's opinion diagnosing PTSD related to a stressor consistent with the rigors and experiences of a combat zone.

Subsequent to this regulatory change, VA has seen accuracy results in PTSD claims greatly improve. This change has improved the process for adjudicating combat PTSD claims, and the veterans who served with those invisible wounds have been able to receive some measure of justice.

At the time of the regulatory change, the issue of MST claims for PTSD was raised in conjunction with the proposed changes for combat related PTSD. VA's response at the time, noted in the July 13, 2010 Federal Register, was to cite the existence of the special rules for adjudicating these types of claims noted in 38 CFR § 3.304(f)(5) and seemed to indicate the mere presence of this special rule obviated the need for any further liberalization of regulations related to PTSD adjudication in MST cases.

The American Legion believes VA's response in that instance needs to be revisited. There are clear parallels to the struggles of veterans fighting to be recognized with service connection for PTSD in combat situations and in situations of sexual trauma. In both cases, the trauma contributes to lasting effects which can reach into every aspect of the veteran's life. In both cases, the reliving of the event as a necessary part of the process of service connection can be devastating and contribute to further trauma. In both cases, there is a long established understanding of the lack of available records to help validate the claim.

The recent change to the PTSD claims model for combat veterans has shown there is a remedy to the failing of the claims process where there is an absence of records. The American Legion believes this is the directions we must look to in order to solve the problems faced by victims of MST in the claims process as they seek service connection for PTSD related to their trauma. Whether this is accomplished through internal regulatory change by VA along the lines of the initiative displayed in improving the process for combat veterans, or by change of law, the important message is that the system needs to change to help these veterans.

If a victim of sexual trauma in the military is currently experiencing symptoms of PTSD related to that trauma, a doctor is fully qualified to make that assessment according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) whether the currently utilized DSM–IV or the upcoming DSM–V the important factor is ensuring a diagnosis conforms to careful medical understanding. With a doctor's detailed evaluation, and relating the PTSD to an event in service, the evidentiary requirement for MST victims could be treated in the same manner in which we treat combat veterans. If the described incident is consistent with the nature of sexual trauma and conforms to the diagnosis, the existence of the in service stressor should be conceded by VA.

The veterans in question have already been terribly victimized. Unlike combat veterans, they are unlikely to be hailed as heroes, although the courage to come forward and seek treatment is no less admirable. As a nation we must be reaching out to these veterans and telling them it is not only okay to come forward, but we have to reestablish trust with them.

It is easy to miss this critical consideration when addressing the issue of MST. These are veterans who came forward to serve their country, and their trust has been shattered. In many cases their trust in the system is nil. It is not enough to be a cold, dispassionate system to adjudicate their benefits. We owe them an attempt to restore faith and trust in the system. We owe them an attempt to show their country does not think less of them.

The system needs fixing, but it is not a complicated fix. The lessons of combat PTSD have shown us VA can make these changes on their own initiative, and The American Legion urges them to act now to do so for victims of MST.

The American Legion thanks this subcommittee for the opportunity to come before you today to express our views on this critical issue, and furthermore thanks to this subcommittee for ensuring that the victims of Military Sexual Trauma are not forgotten or allowed to fall by the wayside.

Executive Summary

The American Legion recognizes the obstacles faced by victims of Military Sexual Trauma (MST) when filing for service connection in the disability benefits system. The lack of data in the military records system is a great obstacle to veterans trying to prove service connection. In this way, victims of MST filing for PTSD face very similar obstacles to combat veterans filing for PTSD, in both cases the lack of records is one of the biggest obstacles to obtaining service connection.

In 2010 VA voluntarily fixed their regulations to make it easier for veterans who had served in combat zones to obtain service connection for PTSD related to combat and combat conditions, by relaxing evidentiary requirements for veterans with a diagnosis of PTSD related to combat.

The American Legion believes VA must use its authority to change their regulations in a similar fashion for MST victims seeking service connection for PTSD. Despite the existence of regulations for MST victims that require VA to pay special attention to alternate sources of information which could confirm the occurrence of an event in service, VA adjudicators are inconsistent in applying that special consideration. Therefore, a more substantial regulatory change, on the level of what was done in 2010 for combat victims, is in order to provide justice for MST victims seeking service connection for PTSD.

Prepared Statement of Dr. Barbara Van Dahlen

Thank you for this opportunity to provide testimony regarding the issue of improving the access to care through the Department of Veterans Affairs for veterans who have been sexually assaulted while serving in our military. It is an honor to appear before this Committee, and I am proud to offer my assistance to those who serve our country.

Background on Military Sexual Trauma

Over the past several months we have seen an increase in the attention given to a very serious issue affecting our military community: military sexual assault. One reason for the increase in interest has been the release of a documentary film called *The Invisible War*. The film—which debuted at the Sundance Film Festival and opened in theaters in June—presents the stories of several women and men who were sexually assaulted while serving in the military. The service members who stepped forward to share these stories chose to serve our country by joining the armed forces—and were devastated by the assault they experienced and the lack of support they received from the institution they had devoted themselves to.

The film has received critical acclaim and has stimulated conversations in both the civilian and military communities regarding a brutal reality that affects far too many men and women who serve. In 2011 alone, 3,192 men and women reported that they were sexually assaulted while serving. By telling the painful stories of several victims of sexual assault, the film provides an important framework to understand the impact of this type of attack on those who serve and their families. It sets the stage for discussions and actions that must be taken if we are to protect those who defend our country from attacks that can occur from within. And it confirms that we must ensure services are available for those who have already been harmed.

Understandably, this type of attack and betrayal often leads to the development of severe mental health difficulties for the men and women who are victimized. Indeed, today many of the female veterans treated by the Department of Veterans Affairs and other programs receive a diagnosis of Military Sexual Trauma (MST), and this type of trauma is now the leading cause of post-traumatic stress disorder among female veterans, surpassing combat trauma. In addition, the experience of military sexual assault increases the likelihood of other serious and devastating conditions and consequences such as substance abuse, homelessness, and suicide.

This hearing focuses on a set of very important questions related to assisting the victims of military sexual trauma who seek care through the Department of Veterans Affairs (VA). Specifically, this committee seeks to explore the process and procedures involved in obtaining VA disability compensation benefits for post-traumatic

stress disorder based on military sexual trauma. And it aims to determine how to improve the evaluation process for veterans who have been sexually assaulted so that those in need are quickly identified and treated.

While this issue is getting significant attention today, sexual assault has been affecting—and often destroying—the lives of those who serve for decades. As I began to prepare testimony for this hearing, I had occasion to speak with a colleague who devoted over 20 years of service to the military. He continues to serve as a civilian in a high level position with the Department of Defense. I happened to mention to him that I was invited to testify before this committee on this important topic. After stating that he was about to share something with me that he had never shared with anyone, not even his wife, he told me the following story.

He enlisted in the military at the age of 17. It was the late 1970s. Within the first year of his service, he was sexually assaulted by two men with whom he served, as part of an initiation process. He was humiliated and devastated. He told no one. He said, "There was no one to tell—reporting would have made my life much worse. The stigma would have further damaged me and my career. I felt overwhelming guilt and shame." This veteran suffered the consequences of the attack, psychologically and physically, for years. At one point he contemplated suicide and went so far as to put all his affairs in order and make arrangements for the care of his two-year-old daughter and young wife. His marriage eventually fell apart and he and his wife separated. Fortunately, this veteran found help, repaired his marriage, and has healed psychologically—though he continues to have significant physical problems that stem from the attack that shattered his life 30 years ago.

He shared his story now because he wants the members of this committee to understand that service members who are sexually assaulted are unlikely to report the assault to their command, to their peers, to anybody. Data from the Department of Defense substantiate his claim. Reports indicate that an estimated 86% of service members do not report an assault when it occurs. There are many reasons for this, one being that for 25% of military sexual assault survivors, the person they would report the assault to is *the perpetrator*.

We in the mental health profession know that it is absolutely critical for victims of sexual trauma to seek and receive assistance, support, and treatment as soon as possible. We also know, however, that many who suffer sexual attacks within the military will not seek care while they continue to serve. We must, therefore, ensure that all of those who seek services through the Department of Veterans Affairs for sexual assault once they leave the service are treated as quickly and as supportively as possible.

Trained mental health clinicians are quite capable of determining the veracity of a veteran's claim of sexual assault. The signs and symptoms are well known, and VA mental health providers have already been given the appropriate responsibility for making this type of determination regarding reports of combat stress injuries. It would be appropriate and consistent, therefore, to allow trained mental health professionals to determine—as they currently do within the VA for combat-related trauma—that the claimed stressor of military sexual trauma is adequate to support a diagnosis of post-traumatic stress disorder and that the veterans symptoms are related to the claimed stressor for the purposes of seeking and receiving appropriate care and services through the VA.

Moreover, given the humiliation survivors of sexual assault contend with, it is highly unlikely that many women or men will fabricate stories of military sexual trauma in order to receive VA benefits. In addition the lives that are saved by adjusting the process by which victims of sexual assault can qualify for and receive services through the VA will far out weigh the very few cases that "beat the system."

In addition to changing the process for victims of sexual assault to apply for and receive services through the VA, we should continue to expand the network of providers available to meet the growing needs of the military community at large. The VA has made tremendous strides in recognizing that partnerships with community-based organizations are critical if we are to provide the mental health services that the men, women, and families who serve our country need when they come home to our communities. For example, the Department of Veterans Affairs recently signed an MOA with my organization, Give an Hour, which provides free mental health services to military personnel, veterans, and their loved ones. This MOA will facilitate appropriate referrals to GAH providers from the VA's Veterans Crisis Line. It is easy to imagine how community-based efforts such as those provided by Give an Hour and other organizations can assist the VA in their efforts to provide swift and effective care to those who have given so much to our country.

Scope and History of the Problem

The issue of military sexual trauma has indeed received increased attention over the past few years. Looking at the number of reports filed with DoD in recent years confirms the magnitude of the problem. In 2010 there were 3,158 total reports of sexual assault in the military. The Department of Defense estimates that this number represents only 13.5% of total assaults in 2010. If this estimate is accurate then the total number of military sexual assaults would have been upwards of 20,000. Of the 3,158 reports that were made in FY2010, only 529 ever went to trial.

Of the 3,192 military sexual assaults reported in 2011, service members were the victims in 2,723 of those assaults. Eighty-four percent of the incidents reported occurred in FY11, 14% were related to incidents occurring from FY08 to FY10, and 2% concerned incidents occurring in FY07 and prior. Of the 3,192 reports filed in 2011, only 791 individuals received some form of disciplinary action, and of that group 489 individuals had courts martial charges initiated against them.

On February 15, 2011, fifteen female and two male military veterans filed a class action lawsuit against former Defense Secretaries Donald Rumsfeld and Robert Gates. The case was ultimately dismissed but an appeal is being considered. The film *The Invisible War* profiles several of the victims involved in this class action suit.

But this is not the first time that the issue of military sexual assault has received this type of public attention. Americans became aware of the issue during the Tailhook scandal in 1991. Tailhook refers to a series of incidents in which more than 100 U.S. Navy and Marine Corps aviation officers were alleged to have sexually assaulted or otherwise engaged in "improper and indecent" conduct with at least 87 women at the Las Vegas Hilton.

In July 1992, a series of hearings on women veterans' issues conducted by the Senate Committee on Veterans Affairs brought the problem of military sexual assault to policy makers' attention. Congress responded to these hearings by passing a public law that, among other things, authorized health care and counseling for women veterans who were experiencing mental health consequences resulting from sexual assault or sexual harassment during their military service. Signed into law in November 1992, this public law was later expanded to include male veterans. Following the passage of these laws, a series of Department of Veterans Affairs directives mandated universal screening of all veterans for a history of military sexual trauma and mandated that each facility identify a Military Sexual Trauma Coordinator to oversee the screening and treatment referral process.

Although careers ended and policies changed following the Tailhook scandal, far too many men and women serving in our armed forces continue to be sexually assaulted at home and abroad. Most of these (often young) men and women were unable to protect themselves from an attack from one of their "battle buddies." But why would they think that they would ever need to protect themselves from this type of assault? They joined the military to serve their country. They were taught that those with whom they serve share their dedication and commitment, are there to protect them, are closer than family. It is no surprise that military sexual assault often leads to a shattering of trust and a sense of despair. Many have likened military sexual assault to incest in the sense that many victims of military sexual assault are devastated by the betrayal and brutality they experience at the hands of one of their own.

Fortunately, additional measures are now under way within the military to protect those who serve and to prosecute those who prey on them. Secretary of Defense Panetta has proposed new steps the military will take to address the problem of sexual assaults. One recommended policy change is the requirement that a higher authority within the military review the most serious cases, a step to ensure that cases remain within the chain of command and leaders are held responsible. Secretary Panetta also announced the creation of a special victims unit within each of the services and an explanation of sexual assault policies to all service members within 14 days of their entry into the military. In addition, the secretary has proposed intensified investigations, heightened training, and more resources. These are all excellent recommendations that may begin to stem the tide of victimization. We must also increase access to care for those who have already been affected.

Impact of Military Sexual Assault/Trauma

Military sexual assault has been associated with an increased risk of depression, post-traumatic stress disorder, and substance abuse. Women who have been sexually assaulted in the military are more than four times more likely to have post-traumatic stress disorder than peers who have not been sexually assaulted. They are also more likely to suffer from multiple mental health concerns. In FY2011 19.4% of the OEF/OIF/OND female veterans reported a history of military sexual

assault. In addition, one in five women veterans who present to the VA for health care screen positive for Military Sexual Trauma. Not surprisingly, women who enter the military at younger ages and those of enlisted rank appear to be at an increased risk for MST.

Women and men in the military must face unique challenges associated with the experience of sexual assault. They must decide if they are willing to report the incident—and face whatever personal or professional reprisals that follow. But there are symptoms that all victims of sexual assault share, whether the attack occurs within the military or civilian community. Indeed, in addition to the physical and psychological pain of the attack itself, women and men who are sexually assaulted often experience years of emotional distress, damaged relationships, and overall dysfunction.

Post-traumatic stress disorder refers to a collection of symptoms that occur for a prolonged period of time following a severe trauma. As we know, many victims of sexual assault develop post-traumatic stress. These symptoms can be grouped into three main categories:

— Re-Experiencing: This is a repeated reliving of the event that interferes with daily functioning. This cluster of symptoms includes flashbacks, frightening thoughts, recurrent memories or dreams, and physical reactions to situations that remind a person of the event.
— Avoidance: These symptoms stem from the desire of a person to change his or her routine to escape similar situations to the trauma. Victims might avoid places, events, or objects that remind them of the experience. Emotions related to avoidance are numbness, guilt, and depression. Some individuals have a decreased ability to feel certain emotions like happiness. They might also be unable to remember major parts of the trauma and feel that their future offers fewer possibilities than other people have.
— Hyper-arousal: Hyper-arousal symptoms are primarily physiological. They include difficulty concentrating or falling asleep; being easily startled; feeling tense and "on edge"; and being prone to angry outbursts.

It is easy to see how the presence of one or more of these symptoms can dramatically interfere with one's ability to pursue a career, engage in meaningful relationships, or live one's life.

In addition, victims of sexual assault often turn to alcohol or other substances in an attempt to relieve their emotional suffering. Victims of sexual assault report higher levels of psychological distress and higher levels of alcohol consumption than non-victims. And when compared to non-victims, sexual assault survivors are 3.4 times more likely to use marijuana, 6 times more likely to use cocaine, and 10 times more likely to use other major drugs. Many of the women veterans who are now living among the homeless population in the United States have what is referred to as a "dual diagnosis"—a consequence of the sexual trauma they endured. They have a mental health condition such as post-traumatic stress disorder, depression, or severe anxiety and they have a substance abuse problem, making it even more difficult for them to receive or benefit from treatment for the assault that injured them.

Furthermore, it is common for victims of sexual assault to engage in behaviors that result in physical and/or psychological harm to themselves. Deliberate "self-harm" or "self-injury" refers to incidents when a person inflicts physical harm on him or herself, usually in secret. Some victims of sexual assault may use self-harm to cope with the difficult or painful feelings associated with their experience of sexual trauma. Self-harm can cause permanent damage to the body, as well as additional psychological problems that hinder the healing process, such as guilt, depression, low self-esteem or self-hatred, along with a tendency toward isolation. Some common methods of self-harm include cutting, burning, pulling out hair, scratching, and eating disorders.

For sexual assault victims specifically, self-injury may

— provide a way to express difficult or hidden feelings
— provide a way of communicating to others that support is needed
— provide a distraction from emotional pain
— provide self-punishment for what they believe they deserve
— provide a feeling of control—it is not uncommon to feel that self-harm is the only way to have a sense of control over life, feelings, and body, especially if other things in life seem out of control

Finally, one of the most concerning consequences of sexual assault is associated with the depression that so many experience following an attack. Depression that goes untreated can continue for years following the attack. And untreated depres-

sion results in an increased risk of suicide. Indeed, of the group of men and women who have experienced sexual assault many experience suicidal thoughts, and many attempt or complete suicide.

Access to Care

We know that early intervention following the experience of trauma promotes healing and decreases the likelihood that the trauma will result in chronic and disabling mental health conditions. And we know that it is extremely difficult for victims to overcome the common feelings of fear, guilt, and shame they feel following an assault. As a result, many are reluctant to come forward to report an assault or seek treatment. And we know that if veterans are further victimized by the reporting and investigative process itself, they are likely to suffer additional psychological damage that worsens their condition. We must, therefore, assure that those who seek care for military sexual assault are treated with respect and given the attention and treatment they need and deserve.

We have the systems and programs in place—through the Department of Veterans Affairs, through state and local governmental agencies, and through community-based programs like Give an Hour—to provide the education, support, and treatment that service members who have been sexually assaulted and their families need and deserve. We have treatment strategies that can relieve suffering and heal relationships. We have trained clinicians working within the VA and in surrounding communities who have the requisite skills to accurately assess those who present with symptoms related to sexual trauma. We must allow our trained clinicians to make these determinations so that the veterans who have suffered these acts of betrayal and violation are able to reclaim and rebuild their lives.

Executive Summary

Over the past several months we have seen an increase in the attention given to a very serious issue affecting our military community: military sexual assault. The brutal reality is that in 2011 alone, 3,192 men and women reported that they were sexually assaulted while serving. Meanwhile, reports indicate that an estimated 86% of service members do not report an assault when it occurs. There are many reasons for this, one being that for 25% of military sexual assault survivors, the person they would report the assault to *is the perpetrator*.

Understandably, this type of attack and betrayal often leads to the development of severe mental health difficulties for the men and women who are victimized. Indeed, today many of the female veterans treated by the Department of Veterans Affairs and other programs receive a diagnosis of Military Sexual Trauma (MST), and this type of trauma is now the leading cause of post-traumatic stress disorder among female veterans, surpassing combat trauma. In addition, the experience of military sexual assault increases the likelihood of other serious and devastating conditions and consequences such as substance abuse, homelessness, and suicide.

We in the mental health profession know that it is absolutely critical for victims of sexual trauma to seek and receive assistance, support, and treatment as soon as possible. We also know, however, that it is likely that many who suffer sexual attacks within the military will not seek care while they continue to serve. We must, therefore, ensure that all of those who seek services through the Department of Veterans Affairs for sexual assault once they leave the service are treated as quickly and as supportively as possible by allowing trained mental health clinicians to determine the veracity of a veteran's claim of sexual assault. The signs and symptoms are well known, and VA mental health providers have already been given the appropriate responsibility for making this type of determination regarding reports of combat stress injuries.

In addition to changing the process for victims of sexual assault to apply for and receive services through the VA, we should continue to expand the network of providers available to meet the growing needs of the military community at large. The VA has made tremendous strides in recognizing that partnerships with community-based organizations are critical if we are to provide the mental health services that the men, women, and families who serve our country need when they come home to our communities.

Prepared Statement of Margaret M. Middleton

Chairman Runyan, Ranking Member McNerney and Members of the Subcommittee, thank you very much for the opportunity to appear before you today and offer my testimony on the highly important issue of military sexual trauma and the VA's disability compensation benefits process. My name is Margaret Middleton. I

am the Executive Director and co-founder of the Connecticut Veterans Legal Center. Our mission is to help veterans recovering from homelessness and mental illness overcome barriers to housing, healthcare, and income. I am also a visiting clinical lecturer co-teaching the Veterans Legal Services Clinic at Yale Law School. In both of these capacities I work with veterans seeking VA compensation for PTSD caused by sexual assault in the military.

There are several experts at this hearing who have eloquently testified as to the appalling extent of sexual assault in the military and the scope of the VA's failure to assist those victims. Rather than repeat those statistics I'd like to share some personal experiences I have had in representing veterans to illuminate how the evidentiary standard set forth in Title 38 of the Code of Federal Regulations section 3.304 prevents worthy claimants from receiving compensation they deserve.

As written, 38 CFR 3.304(f) requires that a veteran seeking disability compensation for PTSD caused by MST must provide VA with "credible supporting evidence that the claimed in-service stressor occurred." Part Five of this section includes a long list of potential evidence including police records and medical reports that could be used to corroborate the personal assault. On paper, this requirement seems reasonable. Don't we all like to believe we would seek justice or medical treatment if we were attacked? Working with victims of MST taught me how misinformed that view is. What I have learned from these men and women is that the response to assault in the military is very particular to the military culture and military justice system and should not be thought of as analogous to sexual assault in civilian society. Current Department of Defense practices disincentivize victims from coming forward and seeking justice. Reporting an offender could jeopardize a servicemember's career, destroy his working relationships, or subject her to further harassment or even official punishment. The current regulation demonstrates a fundamental misunderstanding of the nature of sexual assault in the military and it is past time to correct it.

I would like to share with you two examples of veterans I have assisted in applying for VA compensation for PTSD caused by rape in the military and the difficulty of using 38 CFR 3.304(f)(5) in these real world cases. In my teaching capacity, I co-supervised a team of students who helped a female veteran establish service connection for PTSD stemming from a rape at Camp Lejeune in the early 1970's. This veteran had been out drinking at an NCO club. She was 18. The acquaintance walking her home pushed her through a window and raped her in a barren room. This veteran felt tremendous shame and personal responsibility for having been out at night, for having been drinking, and for having trusted the wrong person. She feared that her romantic partner would leave her if she told him she had been raped. What's worse, her assailant bragged about his conquest and her warrant officer told her that "she was the reason why women should not be allowed in the military." She was plagued by PTSD for decades following this assault and was diagnosed and is treated for it by a VA doctor.

Section 3.304 places a heavy burden on a traumatized veteran like this client. The culture and atmosphere of the military discouraged her from reporting this rape, but winning a PTSD claim like hers requires the kind of documentation that can only come from speaking about the event. As time passes producing this type of documentation becomes increasingly difficult. For veterans like our client, whose rape occurred in the 1970s, this is a monumental obstacle to overcome.

As her advocates, assisting this veteran was incredibly involved. Her parents had died, her marriage failed, there were no surviving letters of hers from that time, and no journals or court records. She had lost contact with anyone she had served with thirty years earlier. She had been too ashamed and afraid to seek medical help. Mental health treatment was even less common and more stigmatized then than it is now. She didn't seek a transfer and she wasn't demoted - she just did her job and suffered silently. What documentary evidence is she supposed to provide to corroborate her experience? In a civil case, a judge or jury would be able to weigh the credibility of her testimony and the testimony of a doctor treating her; why does the VA demand more?

Under the current standard, it took hours of work by two incredibly talented Yale law students and an unusually cooperative VA psychiatrist to build her case based on the meager contemporaneous evidence of weight loss and missed duty assignments available in her service records. Most veterans do not have the benefit of a team of law students tirelessly scrutinizing their records, or a VA psychiatrist willing to draft and redraft letters with law students to include the type of language the VA requires. Another option might have been an independent forensic psychiatric evaluation that would have cost several thousand dollars my client did not have and for which the VA would not pay.

The lack of documentary evidence is the rule, not the exception. I recently met with a female veteran being treated at the VA for PTSD caused by MST. While in boot camp, two sergeants had sent everyone out and kept her behind; they raped her in the barracks. Decades later I was the first person she ever told. She didn't tell anyone at the time because it would have meant the end of a career. This veteran, who served in Iraq, achieved the rank of Master Sergeant and retired after 28 years in the military fought back tears as she related this experience. This was only one of the episodes of MST she described.

This veteran's claim also faces an almost impossible evidentiary burden because of 38 CFR 3.304(f)(5). She did not tell anyone what had happened so there are no medical records, no letters home, and no action taken against her assailants. In order to succeed in the Army this veteran felt forced to stay silent and now she will be punished for her silence because the VA will refuse to credit her story based on her testimony alone. As her advocate, it will take me and my team hours of phone calls to family members and old friends, combing through service personnel records, and begging doctors to provide free psychiatric evaluations to prove her claim. This is surely not what the VA anticipated when it adopted 38 CFR 3.304(f)(5), but it is the reality of how it is working in practice.

We create the conditions that compel traumatized people like these two women to remain silent, and then we punish them for that silence by refusing to accept their story when they come forward to tell it. We know that this is grossly unfair, and we know how to fix it. The VA can and should remedy this situation by amending 38 CFR 3.304(f)(5) to provide victims of military sexual trauma the same benefit of the doubt that combat veterans are afforded under 38 CFR 3.304(f)(2). There is no excuse for permitting the current regulation to stand. I hope this subcommittee exercises its responsibility to America's veterans to correct this injustice. Holding this hearing is an important step towards change and I thank you again for the opportunity to testify.

Prepared Statement of Ruth Moore

Good Afternoon Ladies and Gentlemen of the House. My name is Ruth Moore and it is an honor to be among you today. As you know, I am a Military Sexual Trauma survivor who lives with PTSD and Depression. I am here today to share my 23-year struggle to get help from the Veterans Health Administration and disability compensation from the Veterans Benefits Administration.

In 1987, I was a bright, vivacious 18-year-old, serving in the United States Navy. After my training school, my first assignment was to an overseas duty station in Europe. 2½ months after I arrived, I was raped by my supervisor outside of the local club. Not once, but twice. I sought help from the Chaplain, but did not receive any. I tried to move beyond this nightmare, but had contracted a STD. At this point, my life spiraled downward and I attempted suicide. Shortly thereafter, I was medivac'd to Bethesda Naval Hospital, and ultimately discharged from the Navy. No prosecution was ever made against the perpetrator. In hindsight, it was easier for the military to get rid of me, than admit to a rape.

My problems began at the point of separation, as the psychiatrist diagnosed me with a Borderline Personality Disorder. I did not have a personality disorder; this was the standard diagnosis that was given to all victims of MST at that time, to separate them from active duty and protect the military from any and all liability. This travesty continued when I was counseled by "Outprocessing" to waive all claims to the VA, as I "would get healthcare" through my former spouse who was on active duty.

From 1987 to 1993, I struggled with interpersonal relationships, could not trust male supervisors, and could not maintain employment. I filed my first VA claim in Jacksonville which was denied, despite having several markers for PTSD and gynecological problems. My life continued to spiral downward, and I was not able to maintain my marriage. In 1997, I fled from my house and lived out of my van for two weeks before I was able to start rebuilding my life with my present spouse. Things were very difficult, and I developed additional markers of PTSD including night terrors, panic attacks, severe migraine headaches, and insomnia.

In 2003, I refiled for disability and was denied again; however, I enlisted the aid of the Disabled American Veterans. With their help, I was awarded 30% compensation for depression. I was denied PTSD and was told that I did not submit enough evidence to prove that I was raped, despite having submitted a letter from my former spouse who remembered the rape and when I was treated for Chlamydia. Given this eyewitness testimony, the VA still denied this as credible proof. There

was no record of my medical treatment for STD from that duty station as my medical records had been partially expunged. Additionally, I was coded by the Togus VA as having a Traumatic Brain Injury or Brain Syndrome.

In 2009, I entered into my first comprehensive treatment at the VA hospital in White River Junction, Vermont. I met a MST Coordinator who truly listened to me. She began a systemic review of all my records, and determined that they had been expunged by noting the glaring inconsistencies between my lab work, treatment notes, and service record. My psychiatrist and counselor determined that I did not have Borderline Personality Disorder, and the later diagnosis of Traumatic Brain Syndrome was inaccurate. My MST coordinator and I refiled for an increase in disability, and my clinicians wrote supportive records for the VBA to make an accurate determination. They readjudicated my claim to 70% but denied my status as individually unemployable, citing that I did not complete the necessary paperwork.

At this point, I was very frustrated and suicidal with the stresses of the VBA system and claims process. In my final effort, I called the Honorable Bernie Sanders and his staff agreed to investigate why the VA was taking so long and denying part of my claim. I took Mr. Sanders copies of all the paperwork I had filed, including the VBA time and date stamped "missing information" to prove that they had originally received it. Within two weeks, my claim was finally adjudicated to 70% with IU and it was a total and permanent decision. My rating should have been 100% by the VBA criteria, but I was so grateful for a favorable determination that I have not pursued it further.

Ladies and Gentleman, this process took me 23 years to resolve, and I am one of the fortunate ones. It should not be this way. If I had been treated promptly and received benefits in a timely manner, back at the time of my discharge, my life would have been much different. I do not believe that I would have been totally and permanently disabled in my 40's. I would not have had to endure homelessness and increased symptomology to the point where I was suicidal, I would not have miscarried 9 children, and I firmly believe that I would have been able to develop better coping and social skills. Instead, my quality of life has been degraded to the point where I am considering the possibility of getting a service animal to relieve the stress that my husband endures, as my unpaid caretaker.

I am asking you, no – pleading with you, to please consider favorably the legislation that would prevent this from happening to others. Congresswoman Pingree's legislation is one way to change the burden of proof that is required to enable MST survivors to receive proper adjudication for MST and PTSD.

Please, do what is right. Support this legislation, as it is urgently needed. Thank you for your time and audience today.

Prepared Statement of Colonel Alan R. Metzler

Chairman Runyan, Ranking Member McNerney, and members of the subcommittee, thank you for inviting me today to provide you with an update on the progress the Department of Defense has made in caring for victims of sexual assault. I am here as the Deputy Director of the Sexual Assault Prevention and Response Office (SAPRO).

When we last briefed you in 2010, we told you of our efforts to standardize professionalize and institutionalize our Sexual Assault Prevention and Response – or SAPR - program. Since that time, we have pushed forward to expand and improve our support of victims of sexual assault and hold offenders appropriately accountable. Secretary Panetta has put great emphasis on dealing with the problem of sexual assault in the military. He has emphasized that sexual assault is an affront to the basic American values we defend, and it is a stain on the good honor of the great majority of our troops and families.

Before beginning my testimony today, we think is important to start with a baseline of understanding on several important issues:

- Congress has authorized the Department of Veterans Affairs (VA) to provide counseling and appropriate care and services to overcome the psychological trauma that results from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while a veteran served on active duty or active duty for training.
- In the Department of Defense (DoD), the office that I represent is tasked with policy and oversight relating to the prevention and response of sexual assault only. Sexual harassment is addressed by the Equal Opportunity Program. Reported incidents of sexual harassment are not included in our statistics.

- Finally, we would like to remind everyone that our DoD-wide sexual assault policy has been in place since 2005. All reports of sexual assault are of concern to us and we have focused on incidents post-2005, so that we can modify our current policy.

Since our Sexual Assault Prevention and Response policy was instituted in 2005, we have remained committed to our vision: A culture free from sexual assault. One sexual assault is too many. Given the recent changes to the program, we are optimistic that we have set the right initiatives in motion to achieve that vision. The horror of sexual assault demands an immediate response to those persons and behaviors that violate our shared military values of trust, honor and integrity. However, the solution requires more than just an immediate response to the crime. The solution comes from working this problem at every level of military – and civilian – society. From policies that improve the capabilities of institutions, down to the prevention skills and knowledge that empower our individual Service members, these initiatives must be supported and then be allowed to work. I can tell you that the Department will not ignore, tolerate or condone sexual assault. This is our problem. We own it. We must fix it.

Overcoming Barriers to Reporting and Care-Seeking

In 2010, we told you that a chief challenge facing DoD and VA is the fact that sexual assault is one of the most underreported crimes in both civilian and military society. As you know, sexual assault has severe effects on civilian and military victims – but there are other factors that complicate a victim's experience in the military and act as barriers to reporting:

- First, sexual assault often occurs where a victim works and lives. Until recently, a victim was unable to escape painful reminders that keep him or her from moving on from the incident. Victims are also concerned that making a report will cause them to lose their privacy, subject them to unwanted scrutiny, and potentially mark them as weak. They worry that their career advancement will be disrupted.
- Second, when the perpetrator resides in the same unit as the victim, sexual assault sets up a potentially destructive dynamic that can rip units apart. The bond of trust is broken, and when the perpetrator is in a position of authority, victims feel isolated, exploited, and powerless.
- Third, research has found that a history of any kind of assault doubles the risk of posttraumatic stress symptoms when the victim is exposed to combat.[1] We also know that military sexual assault victims are also at greater risk for depression, anxiety disorders, and substance abuse.[2] These psychological problems – these "invisible wounds" – have insidious effects that disrupt lives, families, and military units. Long-term physical effects can include disabilities that impact a person's ability to work, gastrointestinal health, and pain disorders.[3]

Research shows that making a report is the primary means whereby victims access medical care and other support.[4] In 2005, the Department launched a policy to encourage victims to report the crime. The Department offers two reporting options: Restricted and Unrestricted Reporting. The addition of Restricted Reporting as an option was critical first step in our program. Restricted Reporting allows victims to confidentially access medical care and advocacy services to heal their wounds and maintain their privacy by not having to report their victimization to their commander or law enforcement. Restricted Reporting is having the desired effect. By the end of FY11, the Department had received 5,245 Restricted Reports since the option was made available in 2005. We believe that number represents 5,245 victims who would have not otherwise come forward to access care had it not been for the Restricted Reporting option. In addition, 15 percent of those victims who made a Restricted Report converted to an Unrestricted Report, allowing us the potential to hold those offenders appropriately accountable.

New Enhancements and Expansion of the DoD Sexual Assault Prevention and Response Program

In recent months we have expanded or implemented several new initiatives that will further support our victims and encourage prevention.

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[1] Smith, et al., (2008). Prior Assault and Posttraumatic Stress Disorder After Combat Deployment, *Epidemiology,* 19, 505–512.

[2] Kimerling, et al., (2007) American Journal of Public Health, vol. 97, issue 12.

[3] Consequences of Sexual Violence, retrieved from *http://www.cdc.gov/ViolencePrevention/sexualviolence/consequences.html.*

[4] Department of Justice. (2002). *Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992–2000.* Washington, DC: Rennison, Callie Marie.

Military Rule of Evidence 514

Recently the Uniform Code of Military Justice was amended to further institutionalize victim privacy. In December 2011, the President signed an Executive Order that added Military Rule of Evidence (MRE) 514 into military law.[5] MRE 514 is a privilege that took effect on January 12 of this year to protect the communications between a victim and a victim advocate when a case is handled by a military court. This rule allows victims to trust that what is shared with these helping professionals will remain protected. The privilege fills an important gap that once allowed DoD victim advocates and sexual assault response coordinators to be compelled to testify about their communications with victims. We believe MRE 514 is an invaluable contribution to the climate of confidence we are building.

DoD Safe Helpline

The Department is also reaching out to victims with a new initiative that was launched last year. In April 2011, the Department launched DoD Safe Helpline as a crisis support service for adult Service members of the DoD community who are victims of sexual assault. Available 24/7 worldwide, users can "click, call or text" for anonymous and confidential support. The Safe Helpline is owned by the Department and operated by the non-profit Rape, Abuse and Incest National Network (RAINN), the nation's largest anti-sexual violence organization, through a contractual agreement with DoD SAPRO. Safe Helpline has a robust database with a wide-range of military and civilian services available for referral. The database also contains SARC contact information for each Military Service, the National Guard, and the Coast Guard as well as referral information for legal resources, chaplain support, healthcare services, the Departments of Labor and VA, including VA's Veterans Crisis Line, Military OneSource, and 1,100 civilian rape crisis affiliates. In its first year of operation, from April 2011 to April 2012, the Safe Helpline had more than 36,000 unique visitors to its website. Additionally, the DoD Safe Helpline assisted more than 2,700 individuals through its online and telephone hotline sessions and texting referral services. Please note that website visitors and the people helped are not filing reports of sexual assault. Rather, they are confidentially accessing information and finding out about services available to them.

While we designed this service as a crisis hotline, we are finding that many of our service users are talking to us not only about events that just occurred, but also about incidents that occurred several months or even years ago. Given this opportunity for additional assistance, Safe Helpline has expanded its services through the launch of a mobile site and an app that can be downloaded for the iPhone, iPad, and devices with Android operating systems. The mobile site offers all the functionality of the standard website, but packages the content into a format that is easily displayed on a smart phone. The Safe Helpline app gives members of the DoD community affected by sexual assault access to resources and tools to help manage the short-and long-term effects of sexual assault. The app helps users create a plan that is right for them, from exercises that aid in reducing stress to tools to help them transition to civilian life. They can even customize plans and exercises so they can refer back to them at any time. The app is available in the Apple App Store or the Android Market.

DoD Safe Helpline Services for Transitioning Service Members

In order to help our transitioning Service members, we are working to provide a continuum of care with VA for our Service members who have experienced sexual assault. We launched the Safe Helpline Transitioning Service Members (TSM) enhancements on 1 June 2012.

TSMs seeking assistance following a sexual assault may be either unaware of or overwhelmed by the options and resources available to them upon leaving the military. TSMs seeking benefits related to an assault often are dealing with much more than paperwork. They may face concerns over confidentiality, privacy, and stigma. Safe Helpline offers an anonymous, confidential service that provides a safe space to discuss what options are best suited to their needs.

SAPRO collaborated with VA and Department of Labor to streamline pertinent information for military sexual assault victims via the SHL. Through leveraging Safe Helpline's existing infrastructure, the Department is able to present clear and easily accessible information on counseling, benefits determinations, transitions, and employment, which may enable them to reach out for long-term support upon leaving the military. By bridging the gap from DoD to VA for sexual assault victims, we provide a continuum of care from active duty to veteran. TSM resources are eas-

[5] Executive Order 13593, effective on January 12, 2012.

ily accessible through the Safe Helpline via telephone, text, *safehelpline.org,* and through the Safe Helpline app.

DoD-wide Victim Assistance Standards

As we improve our assistance to victims of sexual assault, we are sharing these important lessons with other programs within the Department. Last year, DoD SAPRO worked with the Military Services and other DoD offices to improve the effectiveness and standardization of response to victims of all crimes. The DoD Working Group on Victim Assistance, led by DoD SAPRO, and comprised of victim assistance-related offices at the Office of the Secretary of Defense (OSD) level and Military Service representatives, was established in January 2011, to explore opportunities for achieving efficiencies, improvements, and standardization in victim assistance.

The DoD Working Group determined that standards for victim assistance were needed across the Department. The DoD Working Group drafted standards that establish a foundational level of assistance for victims of crime and harassment across the military community, regardless of DoD program or physical location. These standards are intended to be consistent with those established by national victim assistance organizations and also incorporate the unique needs of the military community. In addition, the DoD Working Group drafted a charter for a senior-level Victim Assistance Leadership Council to promote efficiencies, coordinate victim assistance-related policies, and assess the implementation of victim assistance standards across the Department's victim assistance-related programs. We are now working to codify these victim assistance standards into Department policy.

It is also important that victims get the best medical care possible. Sexual assault victims receiving assistance from DoD have always had an option to receive a general medical examination or a Sexual Assault Forensic Examination, or "SAFE," that recovers evidence of sexual assault for later use in legal proceedings. However, recent improvements in laboratory capabilities and examination procedures required we update the Department's SAFE kit. For this reason, the Department called together civilian and military experts to improve the Sexual Assault Forensic Examination kit, the kit's instructions, and the DD Form 2911 – the SAFE Report. These updates were deployed to the field last year and better align the Department's procedures with national standards recommended by the Department of Justice.

SARC and Victims Advocates Certification Program

Encouraging victim reporting is just one way that the Department is building a climate of confidence – a climate where victims know they will be supported and treated fairly with dignity and respect. When we created our policy in 2005, we established the framework for a coordinated, multidisciplinary response system modeled after the best practices in the civilian community. At the heart of our sexual response system are the Sexual Assault Response Coordinator (SARC) and Victim Advocates. Service members worldwide have access to a 24 /7 response. Because the SARC and Victim Advocate play such an important role in the SAPR program, we have recently moved to professionalize these positions by designing a certification process. Once finalized, the proposed certification program will consist of credentialing that meets national standards, a competencies framework, and training oversight that will help us standardize the assistance provided to sexual assault victims. This certification process will also professionalize roles within the SAPR program and ensure all victims receive assistance from a certified SARC or SAPR Victim Advocate.

Expanded Document Retention

SARCs and Victim Advocates work with victims to help them decide whether to make a Restricted or Unrestricted Report. To ensure that victims make an educated decision in which they are fully informed of their choices, we developed the Victim Reporting Preference Statement (the DD Form 2910) to explain their reporting options. The completed DD Form 2910 is an important record by which the Department documents the victim's report of sexual assault and which of the reporting options he or she selected. In each case, the SARC or Victim Advocate emphasizes that the victim should keep a copy of the DD 2910 in their personal files. This recommendation, to keep the completed DD 2910, is also noted on the bottom of the form.

However, we know that not every individual can keep track of this important document over the course of a military career. We want to ensure victims of sexual assault have access to this and other documents that may be helpful to them. For example, such documents may be needed to establish a Service-connected disability should they suffer lasting effects from the crime. Consequently, the Department issued a Directive Type Memorandum in December 2011 that mandates increased

retention time for this and other sexual assault records. For records that pertain to Unrestricted Reports, including investigative documentation, the SAFE report, and the victim's Reporting Preference Statement, documents will be kept for 50 years.

For Restricted Reports, we also expanded retention times. We expanded retention time for the SAFE kit and associated documentation from one year to five years. As I noted before, a victim making a Restricted Report of sexual assault may convert to an Unrestricted Report at any time. However, at the one-year point following a Restricted Report, the SARC will contact the victim and inform him or her that the SAFE kit and documentation will be available for an additional four years should he or she wish to convert the report. SARCs will also keep a hard copy of the DD Form 2910 – the Reporting Preference Statement – in Restricted Reports for five years.

Expedited Transfer Option

Victims of sexual assault are also informed by the SARC that they now have the option to request a permanent or temporary transfer from their assigned command or base, or to a different location within their assigned command or base. Victims making an Unrestricted Report may make such a request to their commanding officer and must receive an answer within 72 hours. If the victim's commanding officer denies the request for transfer, the victim may appeal this decision to the first general or flag officer in their chain of command, who again has 72 hours to provide a response. Procedures for this new expedited transfer option were issued to the Services in a Directive Type Memorandum in December 2011. The Services were also directed in this memorandum to make every reasonable effort to minimize disruption to the normal career progression of a Service member who reports that he or she is a victim of sexual assault, and to protect victims from reprisal or threat of reprisal for filing a report.

Defense Sexual Assault Incident Database

The Department believes that comprehensive data collection and analysis is vital to policy analysis and program implementation. The Defense Sexual Assault Incident Database (DSAID) received its operating authority in March 2012. The Air Force and National Guard Bureau received training earlier this year and are now actively entering cases into the system. The Marine Corps began using the system on July 1. The Navy SARCs are currently being trained on DSAID and will begin using the system August 1, 2012. We are currently working to interface with the Army's existing data systems and expect DSAID to be fully implemented by the end of August – which is on the schedule that we have been reporting to Congress since January 2010. DSAID has two primary functions: standardization of reporting of sexual assault and managing victim care. Once we have full implementation, we expect that our ability to analyze sexual assault data will be greatly enhanced. In addition, the Victim Reporting Preference Statement (the DD Form 2910) for Unrestricted Reports will be uploaded to DSAID, so they can be maintained for 50 years.

Pre-command Training for Officers and Senior Enlisted Leaders

Changing our culture to achieve our goals involves prevention as well as accountability. One of the methods we are employing is oversight assessments. In January, the Secretary of Defense directed that we conduct a review of pre-command and senior enlisted leader Sexual Assault Prevention and Response (SAPR) training to identify strengths and areas for improvement. DoD SAPRO visited pre-command and senior enlisted leader training conducted by the Marine Corps, Navy, and Air Force and reviewed Army's newly developed Sexual Harassment / Assault Response and Prevention (SHARP) Program training support package for senior enlisted leaders that will be deployed in Summer 2012. DoD SAPRO training experts, subject matter experts, and Service representatives evaluated both the method of delivery of SAPR training, as well as the content of the training, to identify strengths and areas for improvement. SAPRO identified a number of practices the Military Services should continue in their SAPR training for commanders. SAPRO has developed a number of recommendations that are designed to build on the successful practices the Military Services have already put into place, will drive improvements in SAPR training for commanders, and will support the strategic goals of the Department's SAPR program. These recommendations are currently before the Secretary of Defense for his consideration.

Sexual Assault Offense Withhold Policy

To advance accountability, one of the most recent changes in Department policy was directed by the Secretary of Defense in April of this year. Effective on June 28, 2012, the initial disposition of cases of rape, sexual assault, forcible sodomy, and at-

tempts to commit these crimes will be withheld from any officer who is below the O–6 level and who does not hold special court-martial convening authority. This means, commanders at the company or squadron level no longer have authority to decide the initial disposition of cases of rape, sexual assault, forcible sodomy, or associated attempts. In the past, victims have stated that they do not want to report because they believed the offender was more popular or more important to their commander than they were. The presumption was that unit commanders may be less likely to believe the victim and more likely to believe the offender. Now, disposition decisions for these very serious reports of sexual assault will be decided by someone above the level of the unit commander, a commander with greater experience, and senior officers more neutral in perception and in fact will make a reasoned decision.

In April, Secretary Panetta also directed a number of other new policies that we are now working to implement or standardize across the Services:

- Establishing "Special Victims Unit" capabilities within each of the Services, to ensure that specially trained investigators, prosecutors, sexual assault nurse examiners, SARCS, and victim-witness assistance personnel are available to assist with sexual assault cases;
- Requiring sexual assault policies be explained to all Service members within 14 days of their entrance on active duty;
- Allowing reserve and National Guard members who have been sexually assaulted while on active duty to remain in their active-duty status to obtain the treatment and support afforded to active-duty members;
- Requiring annual organizational climate assessments; and
- Mandating wider public dissemination of DoD resources, including information about the DoD Safe Helpline.

Challenges in Caring for Military Victims of Sexual Assault

We need your assistance in removing at least one barrier to victim care; that is state mandatory reporting laws.

Prior to the implementation of Restricted Reporting, victims could not access medical care or advocacy services without the involvement of law enforcement and command. Restricted Reporting is critical to reducing the barriers that prevent victims from accessing care in the military. Despite all of its benefits, Service members in a number of states, including California, do not have the option of Restricted Reporting if they wish to access medical care for a sexual assault. Victims cannot access private medical care and treatment either on or off base. Section 11160 of California's Penal Code requires healthcare practitioners to make a report to law enforcement when a victim presents to them with an injury suspected to be from a criminal act. That report must include the victim's name, whereabouts and a description of the person's injury. There is no discretion allowed by the law on the part of a healthcare provider. Once the healthcare provider notifies civilian law enforcement, we cannot guarantee they will not notify military law enforcement. Once military law enforcement is aware of a sexual assault, it must investigate and command must be notified.

If our active duty members could make Restricted Reports in federally funded facilities, such as a VA Medical Center – no matter where it is located—we believe this would allow us a wider variety of options to offer victims for care. We do not know how many more reports we would have received had the Restricted Reporting option been more available in California. Despite our efforts, no action has been taken to remove this important barrier to reporting. This is a legislative challenge we need help in resolving.

Conclusion

The Department of Defense has made significant progress since 2005 in assisting victims of sexual assault. However, much work remains. Our policy has changed substantially in the last two years since we last appeared before this committee and we are pleased that we have the personal attention of the Secretary of Defense, who has played an invaluable role in helping us push the Sexual Assault Prevention and Response program forward.

Thank you for your time and for the opportunity to testify today. I would be happy to answer your questions.

Prepared Statement of Thomas J. Murphy

Good afternoon, Chairman Runyan, Ranking Member McNerney, and Members of the Subcommittee. I am accompanied today by Ms. Edna MacDonald, Director of the Nashville Regional Office and former Deputy Director for Policy and Procedures in Compensation Service.

Thank you for inviting me to speak today on the timely and important topic of VA disability benefits for posttraumatic stress disorder (PTSD) based on military sexual trauma (MST) and sexual harassment.. The Department of Veterans Affairs (VA) is committed to serving our Nation's Veterans by accurately adjudicating MST claims in a thoughtful and caring manner, while fully recognizing the unique evidentiary considerations involved in such an event. Under Secretary for Benefits Allison Hickey has spearheaded the efforts of the Veterans Benefits Administration (VBA) to ensure that these claims are adjudicated compassionately and fairly, with sensitivity to the unique circumstances presented by each individual claim.

Increase in MST Related PTSD Claims

Over the last several decades, women have entered the military in increasing numbers and now comprise a significant percentage of the Veteran population. Associated with this growth, VA has seen an increase in the filings of PTSD claims based on MST. However, VA recognizes that both men and women can be victims. According to the Veterans Health Administration (VHA), of the population of Veterans screened at its health care facilities, about one in five women and one in one hundred men state that they have experienced such an in-service event.

VA is aware that, because of the personal and sensitive nature of the MST stressors in these cases, it is often difficult for the victim to report or document the event when it occurs. Reasons for this may include fear of reprisal, feelings of shame or guilt, or the perception of an unresponsive military chain of command. As a result, if the MST event subsequently leads to post-service PTSD symptoms and a claim is filed, the available evidence is often insufficient to establish occurrence of the stressor. To remedy this, VA developed regulations and procedures that appropriately allow more liberal evidentiary development and adjudication procedures for these claims.

PTSD Regulations

Under VA regulations at 38 C.F.R. § 3.304(f), service connection for PTSD requires:

- Medical evidence diagnosing the condition;
- A link, established by medical evidence, between current symptoms and an in-service stressor; and
- Credible supporting evidence that the claimed in-service stressor occurred.

VA recognizes that certain in-service stressful events may be difficult to document. As a result, there are five categories of PTSD with particularized rules for establishing occurrence of the in-service stressor. These include stressors related to:

- In-service diagnosis of PTSD;
- Combat;
- Fear of hostile military or terrorist activity;
- Former prisoner-of-war status; and
- In-service personal assault.

MST Claims Processing

As with other PTSD claims, VA will initially review the Veteran's military service records for evidence of MST. Such evidence may include:

- DD Form 2910, Victim Reporting Preference Statement; and
- DD Form 2911, Sexual Assault Forensic Examination Report.

VA's regulation pertaining to in-service personal assault also provides that evidence from sources other than a Veteran's service records may corroborate the Veteran's account of the stressor incident, such as:

- Law enforcement authorities;
- Rape crisis centers;
- Mental health counseling centers;
- Hospitals;
- Physicians;
- Pregnancy tests;

- Tests for sexually transmitted diseases; and
- Statements from:
  - Family members;
  - Roommates;
  - Fellow Servicemembers;
  - Clergy members; and
  - Sexual assault response coordinators and victim advocates.

Evidence of behavior changes is another type of relevant evidence that may establish occurrence of an assault, such as:

- Requests for transfer to another military duty assignment;
- Deterioration in work performance;
- Substance abuse;
- Episodes of depression, panic attacks, or anxiety without an identifiable cause; and
- Unexplained economic or social behavior changes.

Veterans are provided notification regarding the types of evidence that may establish occurrence of an in-service personal assault and are requested to submit or identify any such evidence. When this type of evidence is obtained, VA will schedule the Veteran for an examination with a mental health professional and request an opinion as to whether the claimed in-service MST stressor occurred. This opinion can serve to establish occurrence of the stressor, one element necessary for establishing service connection for PTSD.

VA Efforts to Assist MST Claimants

VA has recently taken numerous other steps to assist Veterans with a timely, equitable, and consistent resolution of these claims.

VBA has placed a primary emphasis on informing VA regional office personnel of the issues related to MST and providing training in proper claims development and adjudication. During August 2011, VBA reviewed a statistically valid sample of approximately 400 MST related PTSD claims. The goal was to assess current processing procedures and formulate methods for improvement. This led to development of an enhanced training curriculum with emphasis on standardizing evidentiary development practices. The VBA "Challenge Training Program," which all newly hired claims processors are required to attend, now includes a module on MST within the course on PTSD claims processing. MST topics are also included in the standard "PTSD and Other Psychological Conditions" training course that all claims adjudicators are required to complete. Additionally, the VA electronic Learning Management System includes learning topics on MST.

To further reinforce the importance of proper MST claims processing, VBA developed and issued Training Letter 11–05, *Adjudicating Posttraumatic Stress Disorder Claims Based on Military Sexual Trauma,* in December 2011. This was followed by a nationwide Microsoft Live Meeting broadcast on MST claims adjudication. The broadcast focused on describing the range of potential markers that could indicate occurrence of an MST stressor and the importance of a thorough and open-minded approach to seeking such markers in the evidentiary record.

In addition to these general training efforts, VBA provided its designated Women Veterans Coordinators with updated specialized training. These employees are located in every VA regional office and are available to assist both female and male Veterans with their claims resulting from MST. They also serve as a liaison with the Women Veterans Program Managers at the local VHA health care facility to coordinate any required health care. As a further means to promote adjudication of these claims consistent with VA's regulation, VBA has recently created dedicated specialized MST claims processing teams within each VA regional office for exclusive handling of MST-related PTSD claims. Additionally, because the medical examination process is often an integral part of determining the outcome of these claims, VBA has worked closely with the VHA Office of Disability and Medical Assessment to ensure that specific training was developed for clinicians conducting PTSD compensation examinations for MST-related claims. This training was provided at a conference attended by VHA clinicians during November 2011. VBA and VHA further collaborated to provide a training broadcast targeted to VHA clinicians and VBA raters on this very important topic which aired initially in April 2012 and has been rebroadcast numerous times. VA is committed to applying the PTSD regulations related to MST in a manner most favorable to our Nation's Veterans and providing those who suffer from PTSD as a result of an in-service personal assault with disability compensation.

Conclusion

In summary, VA has recognized the sensitive nature of MST-related PTSD claims and the difficulty inherent in obtaining evidence of an in-service MST event. Current PTSD regulations provide multiple means to establish an occurrence, and VA has initiated additional training efforts and specialized handling procedures to ensure thorough, accurate, and timely processing of these claims.

This concludes my testimony. I would be happy to address any questions from Members of the Subcommittee.

Question For The Record

Response From: DoD - To: Hon. Robert L. Turner

Question: What is the status of implementation of this new policy (HR1540 Sec 586)?

Answer: The Department of Defense issued Directive-Type Memorandum (DTM) 11–062 to direct the retention of DD Forms 2910 (Victim Reporting Preference Form) and 2911 (Report of Sexual Assault Forensic Exam) for five (5) years in Restricted cases and fifty (50) years in Unrestricted cases. These provisions will be incorporated into Department of Defense Sexual Assault Prevention and Response Program Procedures (Department of Defense Instruction (DoDI) 6495.02) when it is reissued. The document retention provisions relating to archived investigative records will be incorporated into the new Inspector General "Investigation of Sexual Assault in the Department of Defense" (Department of Defense Instruction (DoDI) 5505.mm) when issued.

Materials Submitted For The Record

Service Women's Action Network (SWAN)

July 12, 2011

The Honorable Eric K. Shinseki
Secretary, U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shinseki:

My name is Anu Bhagwati. I am a former Marine Corps Captain and now serve as Executive Director of Service Women's Action Network (SWAN), a national advocacy organization founded by women veterans. It is our goal to transform military culture so that all uniformed personnel have equal opportunity and the freedom to serve in uniform without threat of harassment, discrimination, intimidation, or assault, and to transform the VA so that all veterans, including women, receive the health care and benefits they deserve. Our National Peer Support Helpline receives hundreds of calls each year from veterans and servicemembers. The vast majority of our clients were sexually assaulted or harassed in service, and many report having negative encounters with the VA. Their experiences directly inform our policy work.

I am writing to request a meeting with you and your staff to discuss the need for specific VA reforms with respect to both health care and benefits for Military Sexual Trauma (MST) survivors. We have testified before Congress on the issue of MST reform five times in the last three years. I have no doubt that if you fully understood the obstacles survivors of sexual trauma face both in VHA and VBA, you would implement immediate common sense reforms to help our veterans get the services and benefits they so desperately need.

I am writing to you today not only as the Executive Director of SWAN, but also as a veteran who is intimately familiar with VA's services for MST patients, and for women veterans generally. Since leaving the Marine Corps in 2004, my experiences with VA have been enormously painful and dangerously re-traumatizing due to the poor quality of care I have received on numerous occasions and the inordinate amount of effort it has required to survive and navigate the VHA and VBA bureaucracy.

VBA denied my initial claim for depression and Post-Traumatic Stress Disorder (PTSD) based on sexual harassment despite overwhelming in-service evidence,

statements from witnesses, my own detailed testimony, and several diagnoses from both non-VA and VA mental health providers, including a MST counselor whom I have been seeing for four years. VBA's rejection was devastating. It is only through the support of close family and friends that I continued to fight through my own betrayal, disappointment, and trauma to get what I earned for my service.

Just last month (four years, six lawyers, two Representatives and one Senator later), VBA finally approved my claim.

Had I not finally enlisted the intervention of government officials, I have no doubt my claim would have languished in VBA's bureaucratic labyrinth for several more years. Despite years of trauma reinforced by VBA's ineptitude, I consider myself incredibly lucky. My clients, peers and colleagues continue to suffer because VBA has failed them. Many have been lost to substance abuse or the streets after rejection by VBA, while others have attempted or completed suicide. MST survivors often suffer alone, re-living the shame, hatred and betrayal of a psychological or physical attack by their own peers. When VBA rejects a veteran's MST claim, the department re- triggers the veteran's emotional anguish and psychological turmoil. This heartwrenching rejection is often a reminder of every betrayal that was first experienced when the veteran was raped, assaulted or harassed in uniform. It causes the veteran to re-live the worst moments of his or her life. VBA's denial of a veteran's trauma is an experience from which many veterans simply do not recover.

As you may know, SWAN sued the VA and the Department of Defense last fall for FOIA documentation related to domestic violence, military rape, sexual assault, and sexual harassment. We have received and analyzed the data your department provided, and the results are astonishing. *VBA approves only 32% of MST-related PTSD claims.* This acceptance rate is far less than the acceptance rate of PTSD claims overall. In fact, 53% of total PTSD claims are granted. The evidence suggests enormous bias against veterans whose PTSD originated from MST. There is no doubt that VBA's system for handling MST-related claims needs immediate repair.

It is time now for the VA to treat all veterans with respect, and to provide the same level of care and benefits to our wounded warriors, regardless of the source of their wounds. In 2010, the VA finally adjusted its compensation policy for combat veterans suffering from PTSD, but denied justice to tens of thousands of MST survivors by not doing the same for them. As the policy stands now, VA has set up a cruel double standard that is directly contributing to the re- traumatization and further betrayal of our veterans who suffer from the effects of military rape, sexual assault, and sexual harassment.

The VA's failure to recognize the sacrifices of all wounded warriors is no longer knowledge exclusive to survivors. SWAN helped Representative Chellie Pingree (D–ME) introduce H.R. 930, a common sense bill that would bring parity to the VBA claims process and justice for survivors of military rape, sexual assault, and sexual harassment who suffer from PTSD and other mental health conditions by providing the same standard of evidence as combat PTSD survivors. In addition to creating a single standard for applicants, it would also acknowledge that the wounds of MST survivors are as legitimate as those of combat survivors. It is a bill overwhelmingly supported not only by SWAN but by the veterans' community at large, including Veterans of Foreign Wars, Vietnam Veterans of America, and Iraq and Afghanistan Veterans of America. Additionally, Wounded Warrior Project and Disabled American Veterans have written to the VA to express their support for the proposed evidentiary standard reform for MST survivors.

SWAN has read the VA's recent letter dated June 27, 2011 written by Undersecretary Allison Hickey regarding the processing of MST claims, and finds that it is an insufficient and unsuitable remedy to a systemic institutional problem. The guidance issued in that memo is not based on fact, but rather, on the misplaced hope that regional claims officers will put aside their biases and instead simply trust the evidence presented to them. I and tens of thousands of others over the years have put our faith in the system, and the system betrayed us, once again. MST survivors have put their lives in the hands of far too many individual claims officers for far too long. I urge you therefore to make this evidentiary change a permanent policy for the VA as you have done in the past, without forcing Congress to intervene.

I will be attending the VA's National Training Summit on Women Veterans this weekend in Washington DC, and would be delighted to meet with you before or after your scheduled address to the community. We look forward to hearing from you.

With great respect for your service to our nation,

Anu Bhagwati, MPP
Executive Director, Service Women's Action Network
Former Captain, United States Marine Corps

cc: Brigadier General Allison Hickey, Undersecretary, U.S. Dept. of Veterans Affairs

Major General Irene Trowell-Harris, Director, U.S. Dept. of Veterans Affairs Center for Women Veterans

Dr. Patricia Hayes, Chief Consultant, U.S. Dept. of Veterans Affairs Women Veterans Health Strategic Healthcare Group

Susan McCutcheon, RN, EdD, Director, U.S. Dept. of Veterans Affairs Family Services, Women's Mental Health and Military Sexual Trauma

Members, Senate Veterans' Affairs Committee Members, House Committee on Veterans' Affairs Representative Chellie Pingree (D–ME)

In 2011, the Service Women's Action Network (SWAN), in conjunction with the American Civil Liberties Union (ACLU), filed a Freedom oflnformation Act (FOIA) to obtain data from the Veterans Administration (VA) on gender differences in claims and compensation award for MST- related PTSD claims over the past 10 years. The VA provided the requested data for the fiscal years 2008, 2009 and 2010.

Upon analysis SWAN discovered that during that time only 32.3% of all PTSD claims related to sexual trauma were accepted. Conversely, 54.2% ofPTSD claims overall are accepted. This overall percentage correlates with secondary data obtained by Veterans for Common Sense which shows that 53% of all PTSD claims filed by Iraq and Afghanistan veterans are accepted.

Additionally, a series of difference of proportions test revealed that across 2008–2010 and in each individual year, women are more likely than men to be granted compensation for lv!ST-based PTSD claims. When looking at how much compensation men and women receive, women awarded compensation are more likely than men to receive 10–30% ratings, while men who are awarded compensation are more likely to receive 70–100% ratings.

Gender differences by year SA/SH Claims by Fiscal Year

Year	Percent granted—Men	Percent granted—Women	PIN
2008	22%	34%	<.001/2587.
2009	25%	37%	<.001/3108.
2010	27%	36%	<.001/3825.

Count of Unique Veterans with Initial PTSD Grant By Fiscal Year

Year	Granted(%)
2008	52.9%.
2009	53.3%.
2010	56.4%.

Rates of Evaluation Percentage ofSA/SH PTSD Claims by Gender

	10%	30%	50%	70%	100%
Men	5%	25%	28%	26%	14%.
Women	6.5%	34%	31%	19%	8%.

Sexual Assault/Harassment PTSD Claims, FY08–10

Sexual Trauma/Harassment		FY08				FY09				FY10			
		Grant	Denial	Total		Grant	Denial	Total		Grant	Denial	Total	
A. GranUDenial Summary	Male	186	651	837		242	740	982		350	943	1293	
	Female	601	1149	1750		787	1339	2126		919	1613	2532	
	Unknown	8	16	24		5	26	31		12	32	44	
B. Grant Detail	%Eva!	Male	Female	Unknown	Total	Male	Female	Unknown	Total	Male	Female	Unknown	Total
	0	1	6		7	1	9		10		9		9
	10	13	53		66	5	48		53	21	50		71
	20				0	1	1		2		1		1
	30	49	221	4	274	69	263	2	334	80	306	4	390
	40				0	1			1		2		2
	SO	51	177	2	230	63	242	1	306	107	298	5	410
	60				0				0				0
	70	40	102	2	144	72	157	1	230	94	175	1	270
	80				0				0				0
	90				0				0				0
	100	32	42	1	75	30	67	1	98	48	78	2	128